Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT BENEVA PARK	743 S. BENEVA ROAD SARASOTA, FL 34232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments These are the results of a LNS (Limited Nursing Services) survey conducted on [redacted] at Emeritus at Beneva Park, an Assisted Living Facility (ALF) with a licensed capacity of 120 residents. There were no LNS deficiencies cited at the time of the survey. There were unrelated deficiencies cited during the survey.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT BENEVA PARK	743 S. BENEVA ROAD SARASOTA, FL 34232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 1	A 025		

significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to demonstrate a general awareness of the condition of lower extremity wounds for 1 (Resident #1) of 2 residents receiving home health services.

The findings include:

1. Observation on . . . at 12:30 p.m., revealed Resident #1 was seated in the main dining . . . a chair. Two small telfa dressings were observed to the anterior aspect of his left leg. The nurse who was present at the time of this observation stated the resident presented with 2 small wounds after a . . . and she performed first aid, called the ARNP (Advanced Registered Nurse Practitioner) and the ARNP ordered HHS (Home Health Services).

Interview with the resident on . . . . at 1:05 p.m., revealed he sustained 2 wounds from a recent . . . He did not remember how he . . .

Record review on . . . documented the resident was admitted to the facility on . . . The 1823 Health Assessment dated . . . documents the resident with . . . and . . . and his . . . status as . . .

Further review of the record failed to document

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT BENEVA PARK	**743 S. BENEVA ROAD SARASOTA, FL 34232**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 when, where, why or how the resident . . nor was there documentation to support the injury to his leg, the treatment rendered or whether staff were aware of the condition of the wounds. Interview with the ED (Executive Director) on . . . . at 12:45 p.m., revealed nursing staff are to complete an "Event report" whenever there is an incident involving a resident. Interview with the nurse on . . . . at 12:46 p.m., responsible for performing first aide confirmed no documentation of the "Event." When asked whether the wounds were healing, she stated HHA is responsible for monitoring the wounds. She confirmed lack of documentation showing the facility had a general awareness of the condition of the resident's wounds and whether the family/legal representative was notified of the injury. Class III	A 025		
A 031	58A-5.0182(7) FAC Resident Care - Third Party Services (7) THIRD PARTY SERVICES. Nothing in this rule chapter is intended to prohibit a resident or the resident ' s representative from independently arranging, contracting, and paying for services provided by a third party of the resident ' s choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for continued residency and the resident complies with the facility ' s policy relating to the delivery of services in the facility by third parties. The facility ' s policies may require the third party to coordinate with the facility regarding the resident ' s condition and the services being	A 031		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT BENEVA PARK	743 S. BENEVA ROAD SARASOTA, FL 34232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 3	A 031		

provided pursuant to subsection 58A-5.016(8), F.A.C. Pursuant to subsection (6) of this rule, the facility shall provide the resident with the facility ' s policy regarding the provision of services to residents by non-facility staff.

This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to allow 1 (Resident #1) of 2 residents receiving Home Health Services the option of selecting a specific third party provider of his choice.

The findings include:

1. Observation on ... at 12:30 p.m., revealed Resident #1 was seated in the main dining ... a chair. Two small telfa dressings were observed to the anterior aspect of his left leg. The nurse who was present at the time of this observation stated the resident presented with 2 small wounds after a ... and she performed first aid. She called the ARNP (Advanced Registered Nurse Practitioner) and the ARNP ordered HHS (Home Health Services). She stated she called a home health company and they came out to address the wounds. She confirmed she did not ask the resident whether he would like the facility to address his wounds (as part of their LNS-Limited Nursing Service license) or whether he preferred a home health agency to perform ... care. She stated she's always understood that they apply first aid then call the HHA for ... care.

Interview with the resident on ... at 1:05 p.m., revealed he sustained 2 wounds from a recent ... He confirmed he was never approached by staff as to whether he wanted

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT BENEVA PARK	743 S. BENEVA ROAD SARASOTA, FL 34232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 4 HHS (Home Health Services) or the ALF (Assisted Living Facility) to perform ... care to his left lower extremity. Review of the record on , for Resident #1 documented the resident was admitted to the facility on . The 1823 Health Assessment dated documented the resident with , and his status as . Review of the resident's contract dated , page "6", Section "E. Outside Providers" includes the following: "...If we determine that you require outside assistance, we will assist you in accessing these services and coordinate with any such outside provider to meet your specific service goals, unless you, or your representative, decline such assistance in writing. If you or your representative arranges for outside assistance, such as home health or hospice, upon your request, we shall assist you in accessing these services and shall coordinate with any such outside provider to meet your service goals upon your request..." Interview with the ED (Executive Director) on at 12:50 p.m., confirmed the HHA the nurse called was the facility's own HHA. She stated it is the policy of the facility to permit residents with the option as to whether they would like to receive LNS or choose to go with a HHA so medicare pays for this service. They are not required to go to the facility's own HHA. The ED confirmed the nurse failed to allow the resident and or legal representative to contract with a HHA of his/their choice.	A 031		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT BENEVA PARK	743 S. BENEVA ROAD SARASOTA, FL 34232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 5 Class III	A 031		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus At Beneva Park
743 S. Beneva Road
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a Limited Nursing Service (LNS) survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

sh
Enclosure: State Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue, [illegible]
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372