STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964562	10/17/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sheridan Manor	2415 North 20th Avenue Hollywood, FL 33020	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility relicensure survey was conducted on . . . . . Sheridan Manor, had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observation, record review and interviews, the facility failed to ensure that a resident's health assessment (AHCA Form 1823) was current and reflective of a resident's care needs, for 1 out of 2 sampled residents (Resident #5).

The findings include:

An interview was attempted on . . . . . at 10:21 AM with Resident #5. After the interview, the resident went to the patio to smoke and was observed running his finger through the cigarette butt can and licking his fingers afterward.

A record review conducted on . . . . . of Resident #5 ' s current Health Assessment (AHCA Form 1823) dated . . . . . diagnoses . . . . . Abnormal Gait, and Mood . . . . . The . . . . or behavioral status documented Resident #5 to be alert and oriented, decreased cognition, depressed mood, and impulse control. Further review documented Resident #5 to be independent with all Activities of Daily Living (ADLs). General oversight reflected daily observation of resident ' s well-being, whereabouts and reminders of important tasks.

In an interview conducted on . . . . . at approximately 1:30 PM, the Administrator stated Resident #5 was taken to a local hospital on , after Staff B observed resident taking off his pants and defecating in public areas within the facility. The Administrator said this was the first time the resident had done this. Resident #5 was seen in the Emergency . . . . . treated with a medication for back pain. According to the Administrator, the resident was not evaluated by the . . . . unit.

The Administrator stated Resident #5 sometimes " fakes " his . . . . . and said after working with him for years, she recognizes the difference between a real and fake . . . . The resident also paces at night and sticks with the person on duty. The Administrator stated the staff and other

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residents look after Resident #5. She stated, numerous calls are made to her by staff at all hours of the night due to the resident ' s restlessness. She acknowledged that Resident #5 left the facility over a year ago and did not return after a reasonable time, despite daily observation of the resident ' s whereabouts. The police were called and they found the resident at a local convenience store and brought him back to the facility.

The Administrator stated Resident #5 ' s health assessment form documented the resident as alert and oriented was inaccurate. She stated that the resident's "condition has deteriorated." The Administrator also stated that the facility is not the most appropriate one for Resident #5, since the facility is not a secured, locked-down unit.

According to the Administrator, Resident #5 is seen by a psychologist and psychiatrist but she feels they are not adequately treating Resident #5 for his restlessness or behaviors.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Sheridan Manor
2415 North 20th Avenue
Hollywood, FL 33020

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representatives from this office. Attached is the provider's copy of the State (5000-3547) 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 (30) 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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