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
	AL11911017	A. BUILDING: _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT REGENCY RESIDENCE	5600 LAKESIDE DRIVE NORTH MARGATE, FL 33063

(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 An unannounced complaint inspection survey for CCR#s 2013001900, 2013002784 and 2013007209, was conducted on 8/6/13 through 8/8/13 at Emeritus at Regency Residence. The facility had deficiencies found at the time of the visit. Deficient practice was identified at the following, citations referenced within the relicensure survey. The following citations were issued: 2013001900: A025, A032, A160 2013002784: A092 (Class II), A093, A152 (Class II) This survey was conducted in conjunction with a biennial Standard Relicensure survey, reference the findings above in the separate report. This survey was also conducted in conjunction with an initial Limited Nursing Services specialty license survey, reference the separate report.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

October 24, 2013

Administrator
Emeritus At Regency Residence
5600 Lakeside Drive North
Margate, FL 33063

Re: CCR #2013007209, #2013001900 and #2013002784

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on August 7, 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 **November 24, 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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