STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911767	04/09/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gulf Coast Village Assisted Li	1333 Santa Barbara Blvd Cape Coral, FL 33991	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:
These are the results of a Complaint Survey, CCR# 2014003352 which was conducted on . . . at Gulf Coast Village an Assisted Living Facility (ALF) located at Cape Coral, FL.

The following is description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview, the facility failed to provide care and services according to resident needs for 2 (Residents #6 and #20) out of 21 sampled residents and failed to notify next of kin of a major incident for 1 (Resident #6) out of 21 sampled residents.

The findings include:

1. The facility's manager stated on at 2:30 p.m.: On I received a call from Staff G Licensed Practitioner Nurse (LPN) that works in the facility and reported an incident that involved Resident #6 and Staff H and I. At 4:30 p.m., the manager interviewed the resident. She stated the following: On , Wednesday she thinks, it was about 10:30 p.m., 2 CNAs entered her loudly singing a nursery rhyme and forced her out of her chair to change her brief, she refused and the female aid told her it had to be done now. The resident felt that the CNAs were very aggressive with her. She was) at her right arm because of the aggressive manor that the used to change her brief. She felt humiliated and scared. She was so frightened that stayed awake all night. She felt that the female was the aggressor and the male went along with it.

The Manager discussed her findings with Assistant Administrator, Director of Nursing (DON) and Human Recourses Director. It was agreed that both employees will be suspended. Department of Children and Families (DCF) representative arrived for investigation on . She stated that no outcome of the investigation was provided to her. Both employees were suspended on . and terminated on .

During an interview with Resident #6 on at 11:00 a.m., when asked if the staff treat her kindly and with respect she responded "Sometimes a little rougher. An example would be I was left on the commode for an hour; I couldn't get anyone to answer the call light. But that got fixed. The other one was having 2 aides pull my clothes off to wear a diaper. They were sorry. The man involved, I like him, he didn't want to do it, but the woman talked him into it. I thought she was mean. They put that horrible diaper on me and left. I never had seen either one of them again. I don't know if they lost their jobs or moved to different section. Other than that everybody has been nice. That happened not long ago. I told the manager about it. She brought in 4 people I didn't know that I thought was above her because I thought it was an investigation. They said for me not to worry to it would never happen again."

A record review on of Resident #6's nursing progress notes revealed no documentation of any notification to the resident's family of the situation that occurred on .

The incident which occured on was not reported by the facility to the Department of Children and

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Families Adult Protective Investigation until .

2. On ... at 11:30 p.m., Resident #20 was been toileted by Certified Nursing Assistant (CNA), Staff D and when she stood up to the grab bar lost her balance and . Complaint of left hip pain on movement. Staff C Licensed Practitioner Nurse (LPN) on premises called 911 and resident was transferred to the hospital. Physician notified at 12:00 p.m., and family member in less than 10 minutes. Daughter arrived at the facility as her mother was escorted to the hospital.

Interview with Staff C on ... at 7:13 a.m., revealed that on ... around 11:30 p.m., Staff D reported to her that Resident #20 ...l while he was assisting her in the . She said that Staff D was sent to wake resident up in order to collect ... as ordered by the resident's doctor. She said that for the 14 plus years that she has been working in the facility it has always been a practice to collect ... at the beginning of the night shift because the lab used to come for pick up around 3:00 a.m. She said that she never agreed to that but it was a corporate decision and not hers to make. She said she did not feel it was right to wake up residents so late at night to collect ... when it can easily be done at a.m. hours.

She said that Staff D was present when the resident ...l in the . She said that when she found the resident her head was facing the sink, her feet on the floor, her ... at the shower, and Staff D was behind her sitting her up. She called 911 and the resident went to the Hospital.

She also stated that she had brought to the manager's attention another incident that involved the same employee that took place last year before the holidays and involved a resident that lived on the Harbor unit. She said that after he finished showering the resident, when he was drying her up, resident felt backwards and hit her head on the shower sill. She said that resident did not have apparent injuries at time of the ...l but 2 days after the resident complained of pain, X-Ray was ordered and resident was diagnosed with 7 to 9th ... and wrist ... as well. She said she told the management that she did not believe that Staff D was fit for that job but nothing was done.

An interview was conducted with Staff D, a CNA on . at 8:52 a.m. He stated the following:
Close to 11:15 p.m., I was told to come in to the ... collect ... sample.
I wish we did not have to do that in the middle of the night. I don't think it is fair to the resident to wake up in the middle of the night to get the ... sample. Spoke with manager she knows about it. For the time I work the night shift it's been the same it's always at night time. Usually it's done by the time I come in at 11:00 p.m. The lab people come in around 3:00 a.m. to pick up the sample. She got up and got to the wheel chair and got to the , while she stood up she lost her balance and ...l towards the shower on the opposite of the commode, she was wearing silk clothes. I tried to reach her but she ... It was like her left side gave up. She did not hit her head. I notified the nurse and she called 911. That was the only ...l she had with me.

Interview with Assistant Administrator and Manager on . at 4:00 p.m., revealed that it still the facility's practice to collect . sample in the beginning of the night shift because the lab comes very early in the morning to pick up the sample. They also stated that this is not a common practice and they try to collect the sample early in the morning.

A record review on ... revealed that Resident #20's 1823 dated . documents for special precautions as ...l precautions.

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A record review on ... of Resident #20's chart revealed a Designated Health Care Surrogate and Durable Power of Attorney both dated ... as her daughter.

A record review on ... of Resident #20's physician order date ... for UA C&S if indicated in a.m. increase ... The order was noted on ...

A record review on ... of Resident #20's medical records revealed that it documents she arrived at the Hospital Emergency ... (ER) via ambulance as reported from Gulf Coast Village from ... and ... backwards on a hard floor, landing on her left side and now non ambulatory. She denies ..., loss of ... She was recently hospitalized for ... and found to have a PE ... and was discharged to skilled nursing facility on ... In the ER, she was found to have left hip ... with an ... chip of the lesser ... and ... therapeutic INR. The Impression included: Left hip ... therapeutic INR; ... and gait instability.

Record review on ... of nursing progress note for Resident #20 dated ... at 2:10 p.m., documents "Resident has increase ... crying and ... Had a party with her friends - couldn't remember which day, what time. Did not put in partial, went whole day without it - until family came in - daughter is relieved doctor discontinued ... fluids provided." At 11:30 p.m., "Resident was being toileted and when she stood up to hold on to the grab bar, she lost her balance and ... into the shower. Complained of left hip pain and screaming out with movement, 911 were called."

Record review on ... of the Medication Administration Record (MAR) for Resident #20 shows documentation to collect a UA ... Analysis) at a.m., C & S (Culture and Sensitivity) if indicated for increased ... ... as evidenced by initials on ... (collected) and on ... (not initialed).

Record review on ... for Resident #20 of the lab results of the UA C & S of ... indicate Gram Positive Cocci; >50 white ... count ... was +1 and many ... Lab results for the ... test include many ... & yeast; 25-50 ... protein 1+; positive for ... and 2+ leukocytes.

Record review on ... for Resident #20's Nursing Communication Form for ... Screening dated ... documents mobility - loss of balance; Safety - ... and comments: Resident lost her balance and ... The form was completed on ... - resident admitted in the hospital, no ... orders obtained.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to comply with residents rights to live in a safe environment and be treated with personal dignity for 3 (Residents #6, #13, and #20) out of 21 residents reviewed.

The findings include:

1. Facility's Manager stated on ... at 2:30 p.m.: On ... I received a call from Staff G Licensed Practitioner Nurse (LPN) that works in the facility and reported an incident that involved Resident #6 and Staff H and I. At 4:30 p.m., the Manager interviewed the resident. She stated the following: On ... Wednesday she thinks, it was about 10:30 p.m., 2 Certified Nursing Assistants (CNAs) entered her ... loudly singing a nursery

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rhyme and forced her out of her chair to change her brief she refused, and the female aid told her it had to be done now. The resident felt that the CNAs were very aggressive with her. She was at her right arm because of the aggressive manor that the used to change her brief. She felt humiliated and scared. She was so frightened that stayed awake all night. She felt that the female was the aggressor and the male went along with it.

The Manager discussed her findings with Assistant Administrator, Director of Nursing (DON), and Human Recourses director. It was agreed that both employees will be suspended. Department of Children and Families (DCF) representative arrived for investigation on . She stated that no outcome of the investigation was provided to her. Both employees were suspended on and terminated on .

During an interview with Resident #6 on at 11:00 a.m., when asked if the staff treat her kindly and with respect she responded, "Sometimes a little rougher. An example would be I was left on the commode for an hour; I couldn't get anyone to answer the call light. But that got fixed. The other one was having 2 aides pull my clothes off to wear a diaper. They were sorry. The man involved, I like him, he didn't want to do it, but the woman talked him into it. I thought she was mean. They put that horrible diaper on me and left. I never had seen either one of them again. I don't know if they lost their jobs or moved to different section. Other than that everybody has been nice. That happened not long ago. I told the Manager about it. She brought in 4 people I didn't know that I thought was above her because I thought it was an investigation. They said for me not to worry it would never happen again."

The incident which occured on was not reported by the facility to the Department of Children and Families Adult Protective Investigation until .

2. On at 11:30 p.m., Resident #20 was been toileted by CNA, Staff D and when she stood up to the grab bar lost her balance and Resident complained of left hip pain on movement. Staff C, an LPN, called 911 and resident was transferred to the hospital. The physician notified at 12:00 p.m., and a family member was notified in less than 10 minutes. The resident's daughter arrived to the Facility as her mother was escorted to the hospital.

Interview with Staff C on at 7:13 a.m., revealed that on around 11:30 p.m., Staff D, reported to her that Resident #20 while he was assisting her in the She said that Staff D was sent to wake resident up in order to collect as ordered by the resident's doctor. She said that for the 14 plus years that she has been working in the facility it has always been a practice to collect in the beginning of the night shift because the lab used to come for pick up around 3:00 a.m. She said that she never agreed to that but it was a corporate decision and not hers to make. She said she did not feel it was right to wake up residents so late at night to collect when it can easily be done at a.m. hours.

She said that Staff D was present when the resident in the She said that when she found the resident her head was facing the sink, her feet on the floor, her at the shower, and Staff D was behind her sitting her up. I called 911 she went to the Hospital.

She also stated that she had brought to the Manager's attention another incident that involved the same employee that took place last year before the holidays and involved a resident that lived on the Harbor unit. She said the after he finished showering the resident, when he was drying her up, resident felt backwards and hit her head at the shower sill. She said that resident did not have apparent injuries at time of the but 2 days after

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the resident complained of pain, X-Ray was ordered and resident was diagnosed with 7 to 9th [illegible] and wrist as well. She said she told the management that she did not believe that Staff D was fit for that job but nothing was done.

Interview with Staff D on at 8:52 a.m. He stated the following: Close to 11:15 p.m., I was told to come in to the collect sample. I wish we did not have to do that in the middle of the night. I don't think it is fair to the resident to wake up in the middle of the night to get the sample. Spoke with Manager she knows about it. For the time I work the night shift its ben the same it's always at night time. Usually it's done by the time I come in at 11:00 p.m. The lab people come in around 3:00 a.m. to pick up the sample. She got up and got to the wheel chair and got to the , while she stood up she lost her balance and I towards the shower, I was on the opposite side of the commode, she was wearing silk clothes. I tried to reach her but she It was like her left side gave up. She did not hit her head. I notify the nurse and she called 911. That was the only I she had with me.

Interview with Assistant Administrator and Manager on at 4:00 p.m., revealed that it's still the facility's practice to collect sample at the beginning of the night shift because the lab comes very early in the morning to pick up the sample. They also stated that this is not a common practice and they try to collect the sample early in the morning.

A record review on of Resident #20's 1823 dated revealed that it documents for special precautions as I precautions.

A record review on of Resident #20's chart revealed a Designated Health Care Surrogate and Durable Power of Attorney (POA) both dated as her daughter.

A record review on of Resident #20's physician order date for UA C&S if indicated in a.m. increase The order was noted on

A record review on of Resident #20's medical record revealed that it documents she arrived at the Hospital Emergency (ER) via ambulance as reported from Gulf Coast Village from and I backwards on a hard floor, landing on her left side and now non ambulatory. She denies , loss of She was recently hospitalized for and found to have a PE and was discharged to skilled nursing facility on In the ER, she was found to have left hip with an chip of the lesser and therapeutic INR. The Impression included: Left hip therapeutic INR; and gait instability.

Record review on of nursing progress note for Resident #20 dated at 2:10 p.m. revealed that they document "Resident has increase crying and Had a party with her friends - couldn't remember which day, what time. Did not put in partial, went whole day without it - until family came in - daughter is relieved doctor discontinued , fluids provided." At 11:30 p.m. "Resident was being toileted and when she stood up to hold on to the grab bar, she lost her balance and I into the shower. Complained of left hip pain and screaming out with movement, 911 were called."

Record review on of the Medication Administration Record (MAR) for Resident #20 shows documentation to collect a UA Analysis) at a.m., C & S (Culture and Sensitivity) if indicated for increased as evidenced by initials on (collected) and on (not initialed).

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Record review on for Resident #20 revealed lab results of the UA C & S of indicate Gram Positive Cocci; >50 white count was +1 and many Lab results for the test include many & yeast; 25-50 protein 1+; positive for and 2+ leukocytes.

Record review on for Resident #20's Nursing Communication Form for Screening dated revealed that it documents mobility - loss of balance; Safety - and comments: Resident lost her balance and The form was completed on - resident admitted in the hospital, no orders obtained.

3. On at 6:10 a.m., according to LPN Staff C and Staff D, Resident #13 lost her balance and felt backwards and hit her back on the shower sill. No apparent injury noted at this time. Range of motion. Assisted up by Staff C, resident able to ambulate. Mental status alert before and after the incident, behavior before quiet and after same. Physician and next of kin POA notified immediately. On resident lost her balance backwards hitting her head against the shower. No apparent injury noted. She was assisted up and was able to ambulate with difficulty. Facility staff was to monitor in next shift. Order for X-Ray on left area and wrist. X-Ray was taken on Diagnosis of right wrist and ribs 7 to 9

Record review for Staff D found that he was written up on because a resident stated that the staff had bad bad attitude, does not belong to work here, he did not want him to take care of him anymore. On reported rude behavior, calling supervisor names. On he was reported by another coworker for being very rude to her. On a resident reported him been rough when transferring her. She reported that because she obtain a on her right leg. Staff instead of reporting the incident to the nurse on staff placed a bandage at resident's leg.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview, the facility failed to file an adverse incident report for 1 (Residents #20) out of 21 sampled residents reviewed.

The findings include:

On at 11:30 p.m., Resident #20 was being toileted by Staff D and when she stood up to the grab bar lost her balance and The resident complaint of left hip pain on movement. Staff C, who was on premises, called 911 and the resident was transferred to the hospital. The physician was notified at 12:00 a.m., and a family member was notified in less than 10 minutes. The resident's daughter arrived at the Facility as her mother was escorted to the hospital.

Interview with Staff C on at 7:13 a.m., revealed that on around 11:30 p.m., Staff D reported that Resident #20 while he was assisting her in the She said that Staff D was sent to wake resident up in order to collect as ordered by the resident's doctor. She said that for the 14 plus years that she has been working in the facility it has always been a practice to collect in the beginning of the night shift because the lab would come for pick up around 3:00 a.m. She said that she never agreed to that but it was a corporate decision and not hers to make. She said she did not feel it was right to wake up residents so late at night to collect when can easily be done at a.m. hours.

She said that Staff D was present when the resident in the She said that when she found the

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resident her head was facing the sink, feet on the floor, her [illegible] at the shower, and Staff D was behind her sitting her up. I called 911, she went to the Hospital.

She also stated that she had brought to the Manager's attention another incident that involved the same employee that took place last year before the holidays and involved a resident that lived on the Harbor unit. She said that after he finished showering the resident, when he was drying her up, the resident felt backwards and hit her head on the shower sill. She said that resident did not have apparent injuries at time of the [illegible] but 2 days after the resident complained of pain, X-Ray was ordered and resident was diagnosed with 7 to 9th [illegible] and wrist [illegible] as well. She said she told the management that she did not believe that Staff D was fit for that job but nothing was done.

Interview with Staff D on [illegible] at 8:52 a.m. He stated the following:
Close to 11:15 p.m., I was told to come in to the [illegible] collect [illegible] sample. I wish we did not have to do that in the middle of the night. I don't think is fair to the resident to wake up in the middle of the night to get the sample. Spoke with Manager she knows about it. For the time I work the night shift it's been the same it's always at night time. Usually it's done by the time I come in at 11:00 p.m. The lab people come in around 3:00 a.m. to pick up the sample. She got up and got to the wheel chair and got to the [illegible] while she stood up she lost her balance and [illegible] towards the shower; I was on the opposite side of the commode, she was wearing silk clothes. I tried to reach her but she [illegible] It was like her left side gave up. She did not hit her head. I notified the nurse and she called 911. That was the only [illegible] she had with me.

Interview with Assistant Administrator and Manager on [illegible] at 4:00 p.m., revealed that it still the facility's practice to collect [illegible] sample in the beginning of the night shift because the lab comes very early in the morning to pick up the sample. They also stated that this is not a common practice and they try to collect the sample early in the morning.

A record review on [illegible] of Resident #20's 1823 dated [illegible] revealed that it documents that the resident for special precautions as [illegible] precautions.

A record review on [illegible] of Resident #20's chart revealed a Designated Health Care Surrogate and Durable Power of Attorney both dated [illegible] as her daughter.

A record review on [illegible] of Resident #20's physician order date [illegible] for UA C & S if indicated in a.m. increase [illegible] The order was noted on [illegible].

A record review on [illegible] of Resident #20's medical records revealed that it documents she arrived at the Hospital Emergency [illegible] (ER) via ambulance as reported from Gulf Coast Village from [illegible] and [illegible] backwards on a hard floor, landing on her left side and now non ambulatory. She denies [illegible] loss of [illegible]. She was recently hospitalized for [illegible] and found to have a PE [illegible] and was discharged to skilled nursing facility on [illegible]. In the ER, she was found to have left hip [illegible] with an [illegible] chip of the lesser [illegible] and [illegible] therapeutic INR. The Impression included: Left hip [illegible] ; [illegible] therapeutic INR; [illegible] and gait instability.

Record review on [illegible] of nursing progress note for Resident #20 dated [illegible] at 2:10 p.m., revealed that they document "Resident has increase [illegible], crying and [illegible] Had a party with her friends - couldn't remember which day, what time. Did not put in partial, went whole day without it - until family came in - daughter

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is relieved doctor discontinued fluids provided." At 11:30 p.m. "Resident was being toileted and when she stood up to hold on to the grab bar, she lost her balance and into the shower. Complained of left hip pain and screaming out with movement, 911 were called."

Record review on of the Medication Administration Record (MAR) for Resident #20 shows documentation to collect a UA Analysis) at a.m., C & S (Culture and Sensitivity) if indicated for increased as evidenced by initials on (collected) and on (not initialed).

Record review on for Resident #20 of the lab results of the UA C & S of indicate Gram Positive Cocci; >50 white count was +1 and many Lab results for the test include many & yeast; 25-50 protein 1+; positive for and 2+ leukocytes.

Record review on for Resident #20's Nursing Communication Form for Screening dated documents mobility - loss of balance; Safety - and comments: Resident lost her balance and The form was completed on - resident admitted to the hospital, no orders obtained.

Record review revealed that facility did not file adverse incidents for the incident involving Resident #20.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Gulf Coast Village Assisted Li
1333 Santa Barbara Blvd
Cape Coral, FL 33991

Re: CCR #2014003352

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on . 2014 by representative(s) of 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 days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . 2014 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

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Enclosure: State Form

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

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