STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968928	07/11/2016
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF SARASOTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5311 PROCTOR RD** **SARASOTA, FL 34233**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Extended Congregate Care survey was conducted on I/ at Harborchase of Sarasota, an assisted living facility (license #12753) in Sarasota Florida.

The following is a description of the deficiency.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to ensure tanks were properly secured for 1 (Resident #4) of 3 residents observed using . Pressurized cylinders are likely to over if left unsecured. Such a could cause damage to the cylinder ' s valve or the cylinder itself, resulting in a gas leak. A rapid loss of pressure can turn a cylinder into an unguided missile powerful enough to break through a concrete wall and may also be accompanied by a fire or explosion.

The findings include:

1. A tour was done of all 5 extended congregate care residents. Three of these residents were receiving . Observation of Resident #4 at 10:30 a.m. on I/ revealed the resident had 3 tanks in the closet which were not safely stored in stands.

In an interview on I/ at 9:30 a.m., he Director of Clinical Services agreed the tanks were not safely stored.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Harborchase Of Sarasota
5311 Proctor Rd
Sarasota, FL 34233

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on l, 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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