STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965330	09/01/2016
NAME OF PROVIDER OR SUPPLIER **ARCADIA OAKS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1013 EAST GIBSON STREET** **ARCADIA, FL 34266**	

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

0000 Initial Comments

An unannounced complaint survey for CCR #2016009633 was conducted on / at Arcadia Oaks, an Assisted Living Facility, (license #9716), in Arcadia, Florida.

The complaint contained one allegation which was substantiated with deficiency.

The following is description of the deficiencies.

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, the facility failed to provide a reason for 45-day notice of termination in writing for 1 (Resident #1) of 3 residents surveyed.

The findings included:

Review of Resident #1's contract revealed that it reads, "Facility will accept for admission any paying adult who does not need more than supervision or assistance with taking medications, ambulating, dressing, eating, toileting, bathing and .

Residents must also:
Be free from communicable .
Be able to participate in social and leisure activities,
Be able to communicate their needs,
Be able to evacuate the facility with assistance in an emergency,
Not need nursing or convalescent care upon admission and not need more than seven (7) days any time following admission.
Not be a threat or danger to themselves or others,
Not need more than 24-hour care.

A resident may remain at the FACILITY so long as he or she continues to meet the above criteria and the financial . Judging from the daily physical and emotional needs of the resident, Administrator in the consultation with, and upon certification from the resident's doctor or Advanced Registered Nurse Practitioner, may determine that the resident's needs can no longer be met at the FACILITY. The resident or responsible party will be given a 45-day notice in writing that arrangements for the immediate transfer to an appropriate care setting must be made."

Review of the 1823 for Resident #1 dated showed the resident's needs can be met in the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965330	09/01/2016
NAME OF PROVIDER OR SUPPLIER **ARCADIA OAKS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1013 EAST GIBSON STREET ARCADIA, FL 34266**	

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

assisted living facility.

Reviewed letter of termination dated revealed that it reads, "...in speaking with POA (Power of Attorney), this morning, I made him aware that we are issuing this 45-day notice of termination which would be , , 2016. We have been very accommodating and the patient over the past three years with regard to your financial situation and needs, however, it appears (POA) questions that. Please let us know if you need our help to assist you with a smooth transition to a new home."

No specific reason for termination was listed in the notice.

At 12:20 p.m. on / / , the Administrator said she could not explain the reason the resident was being terminated from the facility until her attorney draft the reason in a letter.

At 1:25 p.m. on / / , Resident #1 said she did not want to leave the facility because she like living there. She said she felt the Administrator issued a letter of termination for retaliation after her POA questions a $1180 charge to her account. Resident #1 said she was never given a reason for her termination.

Class III

0167 Resident Contracts

Based on record review and interview, the facility charged Residents #1 and #2 for third party services without explaining the total amount to be charged and without having a written contract to charge for the services.

The findings included:

1. At 9:30 a.m. on / / , Resident #1's POA (Power of Attorney) said the resident was charged $1180.00 on an invoice dated . He later found out the facility collected monies for a third party service to file for Resident #1's VA (Veteran Administration) benefits. He said he did not feel it was legal to charge for this service and it had never been explained to Resident #1 how much she was to be charged for this service.

Review of an invoice from the facility dated showed the facility did charge Resident #1 an $1180.00 miscellaneous fee.

Review of Resident #1's contract with the facility showed no written documentation of charges for third

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965330	**09/01/2016**
NAME OF PROVIDER OR SUPPLIER **ARCADIA OAKS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1013 EAST GIBSON STREET** **ARCADIA, FL 34266**	

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

party services.

At 1:25 p.m., Resident #1 said she had never been told how much she was going to be charged to for filing for her VA benefits.

2. At 12:23 p.m. on [redacted], Resident #2's daughter said she had never been informed the amount of money she was being charged to have a third party person file for Resident #2's VA benefits. She verified the facility had charged her $1180. She said she was later told by a person at the VA that Resident #2 should not have been charged for this service.

3. At 12:43 p.m. on [redacted], the Administrator said she had no paperwork to show Resident #1 or Resident #2 had agreed to be charged $1180.00 to have a third party person file for their VA benefits.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Arcadia Oaks Assisted Living
1013 East Gibson Street
Arcadia, FL 34266

RE: CCR #2016009633

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

for
Jon Seehawer, R.N.
Field Office Manager

sh
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