STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965744	**07/22/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Barrington At Glenmoor (the)	**230 Towerview Drive Saint , FL 32092**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial licensure survey and a capacity increase appraisal and Financial Monitoring was conducted at The Barrington at Glenmoor in St. , Florida on , 2013. Deficiencies were identified as a result of the survey.

0090-Training - 58A-5.0191(11) FAC
Based on record review and staff interview, the facility failed to ensure that currently employed administrators, managers, direct care staff, and staff involved in resident admissions received at least one hour of training in the facility's policies and procedures regarding within 30 days after employment for 4 of 4 sampled employees. (#1, #6, #7 and #8)

The findings include:

Review of the personnel files for Employees #1, #6, #7 and #8 revealed no documentation of the completion of training.

An interview on at approximately 2:00 PM with the director of nursing services revealed that she was aware of the requirement for training, and she added that she was developing a schedule for newly hired employees to receive the training. She stated that she was unable to find documentation of completed training for Employees #1, #6, #7 and #8.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
The Barrington at Glenmoor
230 Towerview Drive
Saint , FL 32092

Dear Administrator:

This letter reports the findings of a state biennial licensure survey and capacity increase appraisal and financial monitoring visit that was conducted on , 2013 by 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. 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 surveyor. Should you have any questions please call this office at

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure

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