

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 10/02/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964461	(X3) DATE SURVEY COMPLETED 09/24/2013
NAME OF PROVIDER OR SUPPLIER Blake Glenn	STREET ADDRESS, CITY, STATE, ZIP CODE 3933 Erne Street Palm Harbor, FL 34683	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

A biennial state licensure survey was conducted on

The Blake Glenn, assisted living facility, had a deficiency at the time of the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, one of one newly hired staff sampled (B) did not have a statement from a health care provider attesting to this individual's freedom from communicable
Findings include:

Although review of the personnel file of Staff B (hired during the survey revealed a statement, further review of the record found no formal evaluation of this employee from a health care provider regarding his/her freedom from other communicable Interview with the administrator at approximately 1pm on verified that no other assessment had been obtained for this staff person.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Blake Glenn
3933 Erne Street
Palm Harbor, FL 34683

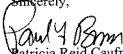
Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on _____, 2013, by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

