STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911784	**11/26/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Glendale House	**1706 North Highland Avenue Clearwater, FL 33755**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A limited nursing services (LNS) monitoring visit was conducted on

The Glendale House, assisted living facility, had a deficiency at the time of the visit.

0161-Records - Staff 58A-5.024(2) FAC

Based on employee file review and interview, the facility failed to ensure staff member file contained verification of freedom from for 2 (#A and #B) of 2 employee file review.

Findings include:

Record review for staff A revealed a date of hire as listed on the employee check list.

The screening record review revealed staff B's result dated . The record did not have an updated test on file.

The administrator was interviewed on at 11:30 AM and she stated the expiration date on the form for staff A indicated she did not need one until the expiration date , however she was informed the expiration date is related to the

Record review for staff B- revealed a date of hire as listed on the employee check list.

The screening record review revealed staff B's result dated . The record did not have an updated test on file.

The administrator was interviewed on at 11:30 AM and she stated she would have staff B get the testing done immediately.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Glendale House
1706 North Highland Avenue
Clearwater, FL 33755

Dear Administrator:

This letter reports the findings of a limited nursing services (LNS) monitoring visit that was conducted on , 2013, by representative(s) 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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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