STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968193	12/09/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cath E-Z Living	907 Pine Ridge Circle Brandon, FL 33511	

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

List of Tags Cited:

St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A limited nursing services (LNS) monitoring visit was conducted on [redacted].

The Cath E-Z Living, assisted living facility, had a deficiency at the time of the visit.

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on record reviews and interview, the facility failed to ensure that the nurse contracted to provide Limited Nursing Services (LNS) to any residents if needed, met the requirements to provide the services by having a current Level 2 background screening (BGS).

Findings include:

Review of Staff B's records provided by the administrator revealed that there was no documentation of a BGS.
Review of Staff B's information on the BGS computer website revealed that Staff B required a new BGS.
Interview with the administrator on [redacted] at approximately 1:10 p.m. revealed that the administrator was not aware that Staff B's BGS was not up to date.
Further review with the administrator on [redacted] at approximately 1:25 p.m. revealed that the administrator spoke with Staff B on the phone and was told that she did the BGS the day of the survey.

Unclassed

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Cath E-Z Living
907 Pine Ridge Circle
Brandon, FL 33511

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

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161