STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968313	05/15/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Verona Gardens, Llc	239 Ne 23rd Avenue Pompano Beach, FL 33062	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey was conducted on [redacted] at Verona Gardens LLC. The facility had deficiencies found at the time of the visit.

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review and interview, it was determined that the facility failed to ensure all direct care staff were in compliance with the Level 2 background screening requirements, for 1 out of 4 employee records reviewed (Employee A).

The findings include:

Record review of Employee A's personnel file revealed a date of hire of [redacted] and a Level 2 background screening for the employee dated [redacted] documenting "eligible". During a review of the Agency's background screening website on [redacted], it was revealed the employee required a new screening.

During an interview with the Owner on [redacted] at 3:45 PM, he acknowledged the findings and stated no further documentation was available review.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Verona Gardens, LLC
239 NE 23rd Avenue
Pompano Beach, FL 33062

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2014 by a representative from 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 (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2014** 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924