STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968421	12/24/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
St Cloud Haven Ii	907 N Taylor Rd Brandon, FL 33510	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And , S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced Biennial licensure survey was conducted on .

The St. Cloud Haven II, assisted living facility, had deficiencies at the time of this visit.

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

Based on record review and interview, the facility failed to ensure that newly hired staff submitted a statement from a health care provider, based on an examination conducted within the previous six months, that the person does not have any signs or symptoms of a communicable including . The facility also failed to ensure annual documentation of freedom from . Failure to ensure that all staff are free from communicable (s) including places residents, employees, and facility visitors at risk of adverse medical consequences.

Findings Include:

One of three employee records reviewed on beginning at approximately 10:30 a.m. contained no evidence of having submitted within 30 days of hire a statement from a health care provider, based on an examination conducted within the previous six months, that the person does not have any signs or symptoms of a communicable including . Two of three employee records reviewed contained no annual documentation of freedom from .

Staff B was hired to provide direct resident care services on . employee's records did not contain a statement of freedom from signs or symptoms of a communicable including . Staff B's employee file also did not contain any evidence of initial or annual testing.

Staff C was hired to provide direct resident care services on -- employee's records contained evidence of testing negative on . As of record review, there was no evidence of annual testing due by .

Per telephone interview conducted with the Administrator on at approximately 3:00 p.m., the Administrator stated she will take care of the missing materials next week and fax the required documentation.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968421	12/24/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0083-Training - First Aid and 58A-5.0191(4) FAC

Based on record review and interview, the facility failed to ensure that a staff member who has completed courses in ( ) and holds a currently valid card documenting completion of such course is in the facility at all times.

Findings Include:

Per record reviews and interviews conducted at the facility on , the facility employs 3 staff who provide direct care to residents; none of the staff are nurses, certified nursing assistants, or home health aides. All 3 staff are certified to provide assistance with self-administration of medication and have completed required updated trainings. One staff person is scheduled to work 2-3 days per week from 8 a.m. through overnight, with shift ending 2-3 days later at 8 a.m. . Separate living quarters are provided for the employees ' overnight stays. The facility census on is 5 residents.

Per observation and interview, Staff A was the one staff person working at the facility during facility visit. Per record review on , Staff A was certified in from - -there was no evidence of updated, current certification.

Per interview conducted with Staff A on at approximately 2:00 p.m., Staff A stated she did not realize her had expired and acknowledged that she has not taken an updated course.

Per interview conducted with the Administrator on at approximately 3:00 p.m., the Administrator stated that she will ensure Staff A has the required updated training and will send documentation to AHCA.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
St Cloud Haven II
907 N Taylor Rd
Brandon, FL 33510

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2014 by representative(s) 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 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(s). Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com