STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967553	**04/20/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
AVA CARES III	**2318 CHERRY RIDGE LANE BRANDON, FL 33511**	

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

0000 - Initial Comments

Assisted Living Facility

A change of ownership (CHOW) survey was conducted on in conjunction with a complaint survey, CCR#2015001876 (aspen event id# 9TVP11).

The Ava Cares III Assisted Living Facility had one deficiency found at the time of the visit.

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

Based on record review and interview, the Assisted Living Facility failed to ensure that 3 of 5 sampled employees (#C, #D, and #E) submitted an initial statement from a health care provider that the employee is free from communicable within 30 days of employment and annual documentation that the employees are free from for 2 of 5 sampled employees (#A and #C).

Findings Include:

On a record review of Employee C's personnel file revealed Employee C's date of hire was 2013. No evidence was located in Employee C's file that Employee C was free from communicable

On a record review of Employees D (hired and Employee E's (hired personnel files revealed there were forms signed by a health care provider stating they were free of communicable but the forms were not dated. There was no way to determine if the forms were completed within 30 days of employment.

On a record review of Employee A and Employee C's personnel file revealed screening records dated for Employee A and for Employee C. No updated screenings were located in Employee A's or Employee C's personnel file.

On at 2:45 PM an interview was conducted with the facility Administrator. The Administrator confirmed the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Administrator
Ava Cares III
2318 Cherry Ridge Lane
Brandon, FL 33511

Dear Administrator:

This letter reports the findings of a Change of Ownership (CHOW) survey that was conducted on . 2015 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,

Paul S Brown

for Patricia Reid Caufman
Field Office Manager

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

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