STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967845	**06/03/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRANQUILITY HAVEN, LLC	**1346 WILDERNESS LANE TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

Conducted Extended Congregate Care monitoring visit on . . Tranquility Haven, LLC had a deficiency found at the time of the visit.

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

Based on record review and interview the facility failed to ensure staff who worked alone, had completed a and First Aid course, from an approved provider, for 2 of 2 sampled staff (Staff A & B).

Findings:

Review of the staff schedule revealed Staff A was scheduled to work on . . . . from 7 AM to 7 PM, and Staff B was scheduled to work on . . . . from 7 PM to 7 AM.

1. Staff A, an unlicensed caregiver, did not have documentation of completion of a current course in . . . and First Aid that was taken from an approved provider. Review of the . . . Certificate revealed it will expire on and the First Aid Certificate will expire on . . . . The courses were taken from American Academy of . . . and First Aid, Inc., and were an online courses.

2. Staff B, an unlicensed caregiver, did not have documentation of completion of a First Aid Course. Review of the . . . . certificate that will expire on , revealed the course was taken from American Academy of . . . and First Aid, Inc., and was an online course.

In an interview with the administrator on . . . . at approximately 11 AM who stated she had previously scheduled the staff to take the courses from an approved provider

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Tranquility Haven, LLC
1346 Wilderness Lane
Titusville, FL 32796

RE: ECC monitoring

Dear Administrator:

This letter reports the findings of a state licensure 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. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review after 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 Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida