STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968748	06/17/2015
NAME OF PROVIDER OR SUPPLIER JACOB'S LADDER FAMILY III ASSISTED LIVING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1504 FISKE BLVD ROCKLEDGE, FL 32955	

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

0000 Initial Comments

The Extended Congregate Care monitoring visit was conducted on / . Jacob's Ladder III Assisted Living Facility had a deficiency found at the time of the visit.

0083 Training - First Aid and

Based on record review and interview the facility failed to ensure, for staff who worked alone, they had completed a and First Aid course, from an approved provider, for 2 of 3 sampled staff (Staff A & B).

Findings:

Review of the staff schedule revealed Staff A was scheduled to work on / / from 8 AM to 4 PM and Staff B was scheduled to work on / from 4 PM to 12 AM.

Review of personnel files revealed:
Staff A, an unlicensed caregiver, did not have documentation of completion of a current course in First Aid.

Staff B, an unlicensed caregiver, did not have documentation of an approved course in and First Aid. Review of the and First Aid certificates revealed they would expire on / / ; they were taken from American Healthcare Academy, an online course and was not an approved provider.

In an interview with the administrator on / / at approximately 3:30 PM who stated she was not aware the courses did not meet the requirements.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Jacob's Ladder Family III Assisted Living, LLC
1504 Fiske Blvd
Rockledge, FL 32955

RE: ECC survey

Dear Administrator:

This letter reports the findings of a state licensure ECC 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 attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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