STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968539	08/13/2015
NAME OF PROVIDER OR SUPPLIER **BARTRAM LAKES ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **6209 BROOKS BARTRAM DR BLDG 200 JACKSONVILLE, FL 32258**	

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

During an interview with the Corporate Director of Clinical Services at 2:30 p.m., she could not explain the lack of documentation of this training in the employee files.

Class III

0090 Training -

Based on record review and staff interview, the facility failed to maintain documentation of the completion of training in the facility's policies and procedures regarding ( ) for three of four sampled employees. (Employees A, B and C)

The findings included:

An review of the employee personnel files revealed that the certificates related to training for Employees A, B and C were not available for review.

During an interview with the Corporate Director of Clinical Services at approximately 2:30 PM, she was unable to explain why the training was missing.

Class III

0091 Training - Documentation & Monitoring

Based on record review and staff interview, the facility failed to ensure that certificates of required employee training included the number of hours of the training program for one of four sampled employee files. (Employee C)

The findings included:

An review of the personnel file for Employee C revealed that her training certificate related to

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SUMMARY STATEMENT OF DEFICIENCIES
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resident rights was missing the number of training hours provided. (Photographic evidence obtained)

An interview with the Corporate Director of Clinical Services at approximately 2:30 PM confirmed that the number of training hours were missing. She stated that she would ensure that the matter was addressed promptly.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Bartram Lakes Assisted Living
6209 Brooks Bartram Drive, Bldg. 200
Jacksonville, FL 32258

Dear Administrator:

This letter reports the findings of a state biennial licensure with Extended Congregate Care survey that was conducted on , 2015 by representatives 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor

KJ/JM/sm
Enclosure

XG90

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone:(904) 798-4201; Fax:(904) 359-6054
AHCA.MyFlorida.com

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