AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968159	11/12/2015
NAME OF PROVIDER OR SUPPLIER **A SAFE HAVEN ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **9000 86TH AVE N** **LARGO, FL 33777**	

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

0000 Initial Comments

Assisted Living Facility Complaint

A complaint investigation (CCR# 2015010893) was conducted at A Safe Haven Assisted Living Facility on . A Safe Haven Assisted Living Facility had a deficiency identified at the time of the investigation.

Z815 Background Screening: Prohibited Offenses

Based on interview and record review, the Assisted Living Facility failed to ensure that a level II background screen re-screen was completed by 31, 2015 for 1 of 4 sampled employees (Employee B) whose last screening dated was conducted between 1, 2009 through 31, 2011.

Findings include:

On a review of Employee B ' s employee file was conducted. Employee B was hired in . An eligible background screen dated was reviewed in Employee B file. No additional background screens were located in Employee B ' s file.
On a search of the Agency for Health Care Administration ' s background screening website was conducted for Employee B. Employee B ' s last screening date was noted on with a "new screening required" result issued from the background screening unit.
On at 3:11 PM, an interview was completed with the assisted living facility administrator. The administrator stated she was unaware of the changes in the background screening requirements and the she believed Employee B ' s 2011 screen was good until 2016.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
A Safe Haven Assisted Living
9000 86th Ave N
Largo, FL 33777

RE: CCR# 2015010893

Dear Administrator:

This letter reports the findings of a complaint 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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.

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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 Brown

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547