STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968748	**11/19/2015**
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

An Extended Congregate Care (ECC) monitoring visit was conducted at Jacob's Ladder Family III Assisted Living on / / . Jacob's Ladder Family III Assisted Living had a deficiency at the time of the visit.

0083 Training - First Aid and

Based on record review and interview the facility failed to ensure staff who worked alone had completed a First Aid course for 2 of 4 sampled staff (Staff A & C).

Findings:

Review of personnel files revealed Staff A, caregiver on the 8 AM to 4 PM shift and Staff C, caregiver on the 12 PM to 8 AM shift did not have documentation to review that indicated they had taken the First Aid course.

In an interview with the administrator on / / at approximately 11:30 AM who stated she did not have documentation the staff had received the training.

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 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 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.

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

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