STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966599	11/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HAVEN ASSISTED LIVING FACILITY	**1525 HAVEN DR OVIEDO, FL 32765**

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

0000 Initial Comments

On / the biennial re-licensure survey with Limited Nursing Services was conducted at Lutheran Haven Assisted Living facility. Deficient practice was identified during the survey.

0161 Records - Staff

Based on personnel record review and interviews the facility failed to ensure 1 of 5 sampled staff records (E) contained the required documentation that included a freedom from communicable statement and a background screening result.
Findings:
Personnel record review for staff E revealed she was hired on and was a Registered Nurse/Director of Nursing (RN/DON). The review revealed a chest x- ray report dated / that indicated no ( ). There was no evidence to confirm she provided the facility a health care provider statement that indicated she was free from communicable including .
Continued review revealed a background screening result dated / that indicated that an Agency review was required. The RN/DON was given the opportunity to locate the documentation.
At 2 PM the DON/RN provided the chest -x-ray result. The result was highlighted in yellow. She pointed out the highlighted area to the surveyor.
She also provided a printed background screening result dated / which indicated she was eligible to work in an Agency for Health Care Administration (AHCA) provider/facility licensure. The determination was made on / .
In an interview with the DON/RN on / at 2:PM who stated she would check with the personnel office for her freedom from communicable statement.
She did not return with a healthcare provider statement.
In an interview with the administrator on / at 3 PM, who confirmed the findings and stated they were unable to locate the healthcare provider statement.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Lutheran Haven Assisted Living Facility
1525 Haven Dr
Oviedo, FL 32765

RE: Relicensure with LNS

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on [redacted] 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 [redacted], 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 [redacted]-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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