STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964808	**12/10/2015**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF OVIEDO**	STREET ADDRESS, CITY, STATE, ZIP CODE **445 ALEXANDRIA BLVD.** **OVIEDO, FL 32765**	

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

0000 Initial Comments

On an Abbreviated Biennial Re-licensure survey was conducted at Savannah Cottage of Oviedo Assisted Living Facility. Deficient practice was identified during the survey.

0078 Staffing Standards - Staff

Based on personnel record review and interview the facility failed to obtain for 1 of 4 staff (B) an annual statement from her health care provider documenting freedom from ( ) and a freedom from communicable statement.

Findings:

Personnel Record review for Staff B hired / revealed the last documentation to confirm she was free from was dated / / (due). There was no documentation to confirm that she was free from communicable .

On at 2 PM, the Assistant Administrator said that Staff B did not have her annual statement and the was no freedom from communicable statement in her record.

Class III

0086 Training - ADRD

Based on personnel record review and interview, the facility maintained a secure area and provided special care for persons with and related (ADRD), and 1 of 3 sampled staff (D) who provided direct care to persons with and Related (ADRD) did not obtain 4 hours of the initial training within 3 months of employment.

Findings:

Review of the Staff Schedule revealed Staff D worked in the Secured Memory Care unit.
Personnel Record Review for Staff D hired revealed there was no evidence to confirm that she had received the initial 4 hours of and Related Level I Training.

On / at 2 PM the Assistant Administrator said that she could not locate any documentation that Staff D had received the initial 4 hours of and Related Level I Training.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Savannah Cottage Of Oviedo
445 Alexandria Blvd.
Oviedo, FL 32765

RE: Relicensure

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 , 2016.** 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 Lorriane Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

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