Separator Page

Assisted Living Facility

SAVANNAH COURT OF OVIEDO II - File: 11964824

Event ID: S1V911 - Begin Date: __/__/____ - LICEN,RELIC

Main Fldr: Statement of Deficiencies

Doc Type: Statement of Deficiencies

Key Val: 120382 LIC_ID: 3753

DMS ID: 3829 PAGE TYPE: SURV

Scanner Operator/Date_____ #Pgs 2 QA Reviewer/Date_____

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964824	01/12/2016
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF OVIEDO II**	STREET ADDRESS, CITY, STATE, ZIP CODE **395 ALAFAYA WOODS BLVD.** **OVIEDO, FL 32765**	

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

0000 Initial Comments

Re-licensure survey was conducted on I/ . Savannah Court of Oviedo II had a deficiency at the time of the visit.

Z815 Background Screening: Prohibited Offenses

Based on record review and interview the facility failed to ensure background screening (BGS) requirements were met for 2 out of 3 sampled employees (Staff A and B.)

Finding:
Staff A's and B's personnel record review revealed Staff A and B were resident care assistants. Staff A was hired on and Staff B was hired I .

Staff A's last BGS was on and Staff B's last BGS was on .

Staff A and B had not been rescreened by , 2015 as required by Section 408.809(5), Florida Statutes.

On I/ at 5:15 p.m. the executive director stated that she was not aware that both staff had to be rescreened for BGS by , 2015.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Savannah Court Of Oviedo II
395 Alafaya Woods Blvd.
Oviedo, FL 32765

RE: Relicensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 30, 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 Lorraine 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