STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967024	R 04/01/2016
NAME OF PROVIDER OR SUPPLIER **LA GRANDE BELLE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5898 ORCHARD POND ROAD** **TALLAHASSEE, FL 32303**	

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

0000 Initial Comments

On / an unannounced revisit to the Limited Nursing Services Monitoring on / / was conducted at La Grande Belle Assisted Living Facility. At the time of the revisit the deficiencies were re-cited.

0077 Staffing Standards - Administrators

Based on staff interview and electronic record review upon the revisit the Owner/Administrator, the person responsible for the operation and maintenance of the facility failed to be in compliance with a Level 2 background screening.

The Findings:
On / upon revisit to LA Grande Belle Assisted Living, a record review was conducted to find no updated background screening.

On / at approximately 10:37AM an interview was conducted via telephone with the Owner/Administrator who reported that he had a rescreening fingerprint done and it returned ineligible. The Owner reported that he was in the process of completing an application for the exemption which he was given 30 days to do it.

On / a record review was conducted of an electronic search from the Agency for Health Care Administration Background Screening conducted on / indicating the Owner/Administrator as, "Not Eligible."

Class II

Z816 Background Screening-Compliance Attestation

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unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
La Grande Belle
5898 Orchard Pond Road
Tallahassee, FL 32303

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on 1, 2016 by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates uncorrected deficiencies identified on the day of the visit. You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure

YOSF

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