STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968623	**03/31/2016**
NAME OF PROVIDER OR SUPPLIER **GOLDEN RETREAT 2 ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **9465 LONGMEADOW CIRCLE BOYNTON BEACH, FL 33436**	

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

0000 Initial Comments

An unannounced re-licensure survey was conducted on 3/31/2016 at Golden Retreat 2 Assisted Living Facilty. The facility had a deficiency at the time of the visit.

0082 Training - / /

Based on record review and an interview, the facility failed to ensure that 1 out of 2 sampled staff members (Staff A) had obtained an initial training on / within 30 days of employment.

The Findings include:

A record review conducted for Staff A, hired on , revealed no documentation of an initial training on / within 30 days of employment. Further record review revealed Staff A provides care and services to the residents residing at the facility.

An interview was conducted on / at approximately 3 PM and the Administrator acknowledged the finding.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Golden Retreat 2 Assisted Living Facility Llc
9465 Longmeadow Circle
Boynton Beach, FL 33436

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2016 by a representative from 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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