STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968716	06/03/2016
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT PALM BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE **380 MALABAR RD SW** **PALM BAY, FL 32907**	

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

0000 Initial Comments

An unannounced complaint investigation (CCR 2016006237) was conducted at Inspired Living at Palm Bay (license 12617) on . . Deficient practice was found at the time of the investigation.

Z816 Background Screening-Compliance Attestation

Based on record review and interview the facility failed to ensure 1 of 4 employees (administrator) completed a level II background screening every five years.
Findings:
In a record review on / of the facility background screening roster, it revealed the administrator's background screening expired on / .
In an interview on / at 8:55 AM, the administrator stated without being asked that she had allowed her background screening to lapse. The administrator stated it was her fault and she wanted to be up front about it.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Inspired Living At Palm Bay
380 Malabar Rd Sw
Palm Bay, FL 32907

RE: CCR #2016006237

Dear Administrator:

This letter reports the findings of a state licensure complaint 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 , 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

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