STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968314	08/08/2016
NAME OF PROVIDER OR SUPPLIER **NOBLE GARDENS OF JACKSONVILLE, FL**	STREET ADDRESS, CITY, STATE, ZIP CODE **7024 WILEY RD** **JACKSONVILLE, FL 32210**	

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

0000 Initial Comments

On , 2016 an bienneial survey with Limited Mental Health and Limited Nursing Services was conducted at Noble Gardens of Jacksonville Assisted Living Facility, License number 12207. Deficient practice was identified during the survey.

Z814 Backaround Screenina Clearinahouse

Based on record review and interview, the facility failed to ensure that 1 of 3 sampled employees were listed on the facility's employee roster on the Agency for Health Care Administrations background screening website.

The findings include:

A review of Employee A's personnel file revealed a hire date of and an eligible Level II background screening dated .

A review of the Agency for Health Care Administration's background screening website on at 12:20 PM on revealed that the facility did not have Employee A as one of the current employees listed under the facility employee roster.

An interview was conducted with the Administrator at 12:29 PM . He confirmed that Employee A was not on Agency for Health Care Administration's background screening website. He stated that he will add her to the employee roster.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Noble Gardens of Jacksonville, FL
7024 Wiley Road
Jacksonville, FL 32210

Dear Administrator:

This letter reports the findings of a state biennial licensure with Limited Mental Health survey that was conducted on , 2016 by representatives 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 surveyors. Should you have any questions please call this officce at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure
XG90

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