STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964515	08/11/2016
NAME OF PROVIDER OR SUPPLIER **BROOKDALE ORMOND BEACH WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE **240 INTERCHANGE BLVD** **ORMOND BEACH, FL 32174**	

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

0000 Initial Comments

A complaint investigation, CCR# 2016006800, was conducted on / at Brookdale Ormond Beach West (License # AL9064). Brookdale Ormond Beach West had deficiencies found at the time of the survey.

Z816 Background Screening-Compliance Attestation

Based on employee record review and staff interview, the facility failed to ensure 1 employee that had had a break of employment of 90 days or more in a sample 4 received a new Level II screening and was found eligible prior to working at the facility. (Employee C).

The findings include:

During an interview with the Associate Executive Director on / at 11:20 AM he stated, he was responsible for the employee records and was not aware of the need to conduct a new Level II background screening when a new employee had had a break in employment from a position that required level 2 screening for more than 90 days.

Employee record review for Employee C (hired 3232016) found a Level II background screening with a / eligible date. Record review of Employee C's application found her most recent employment prior to working at the facility ended in of 2015.

Employee C was interviewed on / at 11:34 AM. She confirmed she had a break in employment from until hired

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale Ormond Beach West
240 Interchange Blvd.
Ormond Beach, FL 32174

RE: CCR #2016006800

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by a representative 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. Should you have any questions please call this office at -4201.

Sincerely,

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

NH/JM/sm
Enclosure
XG90

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