STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963806	08/10/2016
NAME OF PROVIDER OR SUPPLIER **ORMOND IN THE PINES**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 CLYDE MORRIS BLVD** **ORMOND BEACH, FL 32174**	

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

0000 Initial Comments

A complaint investigation, CCR# 2016006227, was conducted on at Ormond in the Pines (License #AL5535). Ormond in the Pines had deficiencies found at the time of the survey.

0161 Records - Staff

Based on record review and staff interview, the facility failed to maintain personnel files with a job description for 1 of 7 sampled employees (Employee A) and with required training for 1 of 7 sampled employees. (Employee G)

The findings include:

The Manager (Employee A) was asked on at 11:45 AM for the job description for himself. He stated, he should have done one for himself as he does one for everyone else. He was not able to provide one.

Record review of the employee file for Employee G (hired on) found no evidence of training. The findings were confirmed through interview with the manager on at 12:00 PM. The manager stated, he did not have access to any of Employee G's training. He also stated, the training was in the computer and only the employee could access his training.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Ormond in the Pines
101 Clyde Morris Blvd.
Ormond Beach, FL 32174

RE: CCR #2016006227

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, QHDP
Health Facility Evacuator Supervisor
Division of Health Quality Assurance

NH/JM/sm
Enclosure
XG90

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