

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/06/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910252	(X3) DATE SURVEY COMPLETED 08/23/2016
NAME OF PROVIDER OR SUPPLIER INN AT FREEDOM SQUARE (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 10801 JOHNSON BLVD. SEMINOLE, FL 33772	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On , 2016 a biennial re-licensure survey with limited nursing services (LNS) was conducted at The Inn at Freedom Square. Deficient practice was identified during the survey.

(License number 4759)

0078 Staffing Standards - Staff

Based on interview and record review, the facility failed to provide proof that newly hired staff submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable (Communicable Statement), within 30 days after beginning employment, for 1 (Staff C) of 4 employee records reviewed.

Findings included:

A review of Staff C's employee record conducted on showed a date of hire of . Staff C's record also showed a lack of a Communicable Statement.

The administrator was interviewed at 3:08 PM on concerning Staff C's Communicable Statement. The administrator reviewed Staff C's record and stated that it wasn't there but would check elsewhere. The administrator was interviewed again at 4:19 PM on and stated that Staff C's Communicable Statement was not available.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 1, 2016

Administrator
Inn At Freedom Square (The)
10801 Johnson Blvd.
Seminole, FL 33772

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited nursing services (LNS) that was conducted on September 1, 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 September 1, 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,
Patricia Reid
for Patricia Reid Cauffman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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