AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967919	09/07/2016
NAME OF PROVIDER OR SUPPLIER **AMBITIOUS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3939 COUNTRY PL** **WINTER HAVEN, FL 33880**	

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

0000 Initial Comments

Assisted Living Facility

On , a complaint survey, (CCR# 2016006754), was conducted at Ambitious Assisted Living Facility. Deficient practice was identified during the survey.

(License # 11988)

Z815 Background Screening: Prohibited Offenses

Based on observation, record review and interview, the facility failed to ensure that 1 (Staff A) of 5 employees whose records were reviewed in employee files, had an eligible status for Level II background screening.

Findings included:

On a review of staff A personnel file showed evidence of the most recent background screening on file was dated . Surveyor reviewed the AHCA (Agency for Health Care Administration) background screening website on . The AHCA (Agency for Health Care Administration) background screening website indicated that a "New Screening is required" for staff A. During a interview with staff A on / 10:53 A.M. Staff A reviewed the her personnel with surveyor and confirmed findings. Staff A stated she provides daily direct care to all residents who currently reside at the facility.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
Ambitious Assisted Living
3939 Country Pl
Winter Haven, FL 33880

RE: CCR# 2016006754

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on [redacted], 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the identified deficiency. Submit summary and documents to the Field Office no later than [redacted], 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 deficiency 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.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

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,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90