STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922334	09/27/2016
NAME OF PROVIDER OR SUPPLIER **SPRING HAVEN RETIREMENT COMMUNITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1225 HAVENDALE BLVD NW** **WINTER HAVEN, FL 33881**	

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

0000 Initial Comments

Assisted Living Facility

Three complaint investigations, (CCR# 2016007556, CCR# 2016009500, and CCR# 2016009521) was conducted at Spring Haven Retirement Community on . Spring Haven Retirement Community, Assisted Living Facility, had a deficiency at the time of the investigation.

(License number 5504)

0086 Training - ADRD

Based on interview and record review, the facility, which maintained a secured area for persons with and Related (ADRD), failed to ensure that facility staff who had regular contact with residents with ADRD received required training for 2 (Staff A and Staff C) of 3 employee records reviewed.

Findings included:

A review of Staff A's employment record showed a date of hire of / . A review of Staff C's employment record showed a date of hire of . The reviews of Staff A's and Staff C's record revealed no proof of required ADRD Level I within 3 months of employment or ADRD Level II training within 9 months of employment. Facility records and observations showed that both Staff A and Staff C provided direct care to residents at the facility.

The assistant executive director was interviewed at 4:00 PM on concerning the lack of proof of required ADRD Level I and Level II training for Staff A and Staff C. The assistant executive director stated at 4:37 PM on that there were no completed training certificates available.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Spring Haven Retirement Community
1225 Havendale Blvd Nw
Winter Haven, FL 33881

RE: CCR# 2016007556, CCR# 2016009599, & CCR# 2016009521

Dear Administrator:

This letter reports the findings of three complaint surveys that were conducted on , 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 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 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.

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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