| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967553 | 11/03/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**AVA CARES III** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2318 CHERRY RIDGE LANE**<br>**BRANDON, FL 33511** | |

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

**0000 Initial Comments**

Assisted Living Facility

On / , a biennial relicensure survey was conducted at Ava Cares III (Lic. #11578). Deficient practice was identified during the survey.

**0078 Staffing Standards - Staff**

Based on record review and interview, one of three staff sampled (A) had not had their freedom from ( ) documented on an annual basis.

Findings include:

A personnel record review during the survey found that the latest statement for Staff A (hired 2013) was from . Interview with Staff A at 1:25pm on / provided no clarification.

Class III

**Z828 Administrative Fines: Violations**

Based on observation and interview, the facility exceeded its licensed capacity by at least one (1) resident.

Findings include:

Interview with both the designee at 10 am as well as the administrator at 11 am on / indicated that the census was six (6) and that they had "one (1) respite resident." Although review of the facility admission and discharge log did not find this individual's name entered thereon, according to the administrator, the resident "had been living at the facility off and on since / ." She further acknowledged that there were periods of time during 2016 when all of her six (6) beds were full, and this respite client was concurrently occupying the seventh bed; the administrator claimed to be unaware that respite residents counted against facility census figures.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Ava Cares III
2318 Cherry Ridge Lane
Brandon, FL 33511

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 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 , 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,

FOR Patricia Reid Caufman
Field Office Manager

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

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