STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967416	**11/07/2016**
NAME OF PROVIDER OR SUPPLIER **SUNHAVEN VILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **11810 NW 30TH PLACE SUNRISE, FL 33323**	

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

Z813 Results of Screening & Notification In File

Based on record review and interview the facility failed to ensure that a signed Attestation of compliance with chapter 435 was in the employee's personnel file, for 5 of 5 (Staff A, B, C, D, and F) staff records reviewed.

The findings include:

Personnel record reviews conducted on / revealed that Staff A (hire date of /), Staff B (hire date of / /), Staff C (hire date of / /), Staff D (hire date of), and Staff E (hire date of) all lacked evidence of a signed Attestation of compliance with chapter 435, as required.

In an interview conducted on / at 1:41 PM with the Administrator, she confirmed that all the staff identified above were current staff members, she then reviewed the files and confirmed the findings.

unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Sunhaven Villa
11810 NW 30th Place
Sunrise, FL 33323

Dear Administrator:

This letter reports the findings of a state licensure 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb

XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com