AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968422	**11/14/2016**
NAME OF PROVIDER OR SUPPLIER **AVA CARES**	STREET ADDRESS, CITY, STATE, ZIP CODE **1007 BROOKER ROAD BRANDON, FL 33511**	

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

Z814 Background Screening Clearinghouse

Based on observation, interview and record review, the facility failed to maintain the employment status of direct care staff within the AHCA background screening clearinghouse (Clearinghouse), within 10 days of initial employment, for 1 (Staff B) of 3 employees sampled.

Findings included:

A review of employee records conducted on /16 showed the date of hire for Staff B was . Staff B was observed providing assistance to the residents of the facility on .

A review of the employee roster in the Clearinghouse was conducted at 1:14 PM on and Staff B was not listed.

Administrator was interviewed at 1:15 PM on and shown the current employee roster in the Clearinghouse. Administrator acknowledged that Staff B ' s name was not entered and stated that this would be corrected.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Ava Cares
1007 Brooker Road
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,

FOV Patricia Reid ufman
Field Office Manager

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

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