STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966850	**12/27/2016**
NAME OF PROVIDER OR SUPPLIER **GOLDEN LIFE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **200 SE LINCOLN CIRCLE N** **SAINT PETERSBURG, FL 33703**	

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

0000 - Initial Comments

Assisted Living Facility

On 27th 2016 a biennial survey was conducted at Golden Life Manor Assist Living Facility. Deficient practice was identified at Golden Life Manor during the survey.

License: 11015

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, that facility failed to ensure that the Clearinghouse Employee Roster was updated to reflect the current employees.

Findings included:

Review of facility's current staff list and the Clearinghouse Employee Roster revealed that none of the two employees were listed on the roster.
During interview with the administrator, conducted on at 12:15 p.m, the administrator confirmed that none are actively listed on the Clearinghouse Employee Roster.
Administrator furnished a facility staffing schedule with two active employee names. None of the employees in the staffing schedule were listed in the Clearinghouse Employee Roster.

Unclassed

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Golden Life Manor
200 Se Lincoln Circle N
Saint Petersburg, FL 33703

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 , 2017.** 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

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