

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 02/02/2017
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966172	(X3) DATE SURVEY COMPLETED 01/31/2017
NAME OF PROVIDER OR SUPPLIER HIGHLANDS (THE) AT THE GLENRID	STREET ADDRESS, CITY, STATE, ZIP CODE 7333 SCOTLAND WAY SARASOTA, FL 34238	

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

0000 - Initial Comments

An unannounced complaint survey for CCR#2016013823 was conducted // // at Highland at the Glenridge, an Assisted Living Facility (license #10453) in Sarasota, Florida.

The complaint contained 1 allegation of which was substantiated

The following is description of the deficiency.

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

Based on record review and interview the facility failed to ensure the names of staff members were added to the employee roster for 2 (Staff#6 and #8) of 4 staff reviewed.

The findings included:

Record review for Staff #6 found a hire date of This staff was not found on the facility's employee roster.

Record review for Staff #8 found a hire date of This staff person was not found on the facility's employee roster.

The staff employee list for the facility contained a total of 35 names. 4 names were listed on the facility's employee roster.

On 1/31/2017 at 12:04 p.m., the Human Resource Director said all staff on the employee list for the facility are not included on the facility's employee roster.

Unclassified



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Highlands (the) At The Glenrid
7333 Scotland Way
Sarasota, FL 34238

RE: CCR #2016013823

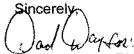
Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2017
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** , 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. Should you have any questions please call this office at 239-335-1315.

Sincerely,

Jon Seehawer, RN
Field Office Manager

JS/arb
Enclosure

XG90

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL
Phone: (239) 335-1315; Fax: (239) 338-2372
AHCA.MyFlorida.com



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