STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966892	**01/24/2017**
NAME OF PROVIDER OR SUPPLIER **HANNAH'S ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1909 NW 12TH AVE** **CAPE CORAL, FL 33993**	

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

0000 - Initial Comments

An abbreviated state relicensure survey was conducted on 1/ at Hannah's Assisted Living Facility, an assisted living facility (License #11966892), in Cape Coral, Florida.

The following deficiency was found at the time of the survey:

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

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

Based on record review and interview, the facility failed to ensure 2 (Staff A, B) of 2 employees reviewed had the status updated within 10 days on the Agency's Background Screening Clearinghouse roster pursuant to Chapter 435.

The findings included:

1. Record review noted the Staff A, Certified Nursing Assistant, was employed by the facility on . On / , review of the background screening website noted Staff A did not appear on the facilities current employee roster.

2. Record review noted the Staff B, Administrator, was employed by the facility on / . On / , review of the background screening website noted Staff B did not appear on the facilities current employee roster.

3. On / at 12:50 p.m. the Administrator confirmed the facility did not update the employment history for Employees A and B with the Florida Background Screening Clearinghouse upon employment within 10 business days. She said she was not aware of the requirement

Unclassified.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Hannah's Assisted Living Facility
1909 Nw 12th Ave
Cape Coral, FL 33993

Dear Administrator:

This letter reports the findings of a state licensure 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. 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:
Enclosure: State (5000-3547) Form

XG90

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