

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911836</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/14/2023</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**DEERFOOT MANOR ALF**

**374 DEERFOOT ROAD  
DELAND, FL 32720**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | Initial Comments<br><br>A relicensure survey with two complaints (2023007019, 2022011374) was conducted at Deerfoot Manor Assisted Living Facility on ..... Deficient practice was identified at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A 000               |                                                                                                                          |                          |
| A 078<br>SS=D            | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF:<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable ..... The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>1. Evidence of a negative ..... examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual ..... examination requirement. An individual with a positive ..... test must submit a health care provider's statement that the individual does not constitute a risk of .....<br>2. If any staff member has, or is suspected of having, a communicable ....., such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable ..... | A 078               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911836</b>         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DEERFOOT MANOR ALF</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>374 DEERFOOT ROAD<br/>DELAND, FL 32720</b> |                                                                                                                          |  |                                                                    |
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| A 078                                                         | <p>Continued From page 1</p> <p>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on employee record reviews and interviews, the facility failed to maintain a statement indicating freedom from communicable in the employee records for 2 out of 3 employees reviewed (Employee A and B).</p> | A 078                                                                                  |                                                                                                                          |  |                                                                    |

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|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 078                    | <p>Continued From page 2</p> <p>The findings include:</p> <p>A review of the employee record on _____ for Employee A, caregiver, revealed a hire date of _____. No communicable _____ statement was on file.</p> <p>A review of the employee record on _____ for Employee B, caregiver, revealed a hire date of _____. No communicable _____ statement was on file.</p> <p>An interview was conducted with the Administrator on _____ at 3:00 p.m. She confirmed the communicable _____ statements were missing and would have to get them done.</p> <p>Class III</p> | A 078               |                                                                                                                          |                          |