

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/17/2025
NAME OF PROVIDER OR SUPPLIER THE GABLES OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments A biennial re-licensure survey was conducted at The Gables of Tallahassee, an assisted living facility located in Tallahassee, FL, from - . A generator assessment and a complaint investigation for complaint #2025007809 was performed concurrent to this survey. Deficiencies were identified at the time of the survey.	A 000			
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (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. 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 . 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	A 078			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

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A 078	Continued From page 1 provider indicating that the individual does not constitute a risk of transmitting a communicable (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. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (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. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (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. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that staff completed the physician's statement indicating the staff was free	A 078			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE GABLES OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

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A 078	Continued From page 2 from communicable in the staff's files, for 3 of 4 staff sampled (Staff member A, B, and D). The findings include: On a record review was conducted for Staff A, a Resident Assistant hired on ; Staff B, a Medication Technician hired on ; and Staff D, a Resident Assistant hired on . None of these staff members had a statement from a Physician, Physician Assistant, or Nurse Practitioner attesting that they are free from communicable . Further review of Staff B's record revealed there was not a current () skin test on file, the last dated skin test was on . On at approximately 1:30 PM, an interview was conducted with the facility's Business Office Manager, who stated that she was unaware of the statement requirement. She was also not aware that the skin test was required annually. CLASS III	A 078		