STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964869	06/20/2013
NAME OF PROVIDER OR SUPPLIER **Zephyrhills Health And Rehabilitation Ctr**	STREET ADDRESS, CITY, STATE, ZIP CODE **7350 Dairy Road Zephyrhills, FL 33540**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Assisted Living Facility

A biennial state licensure survey was conducted on .

The Zephyrhills Health & Rehabilitation Center, assisted living facility, had a deficiency at the time of the visit.

0181-Emergency Mgmt - Plan Approval 58A-5.026(2) FAC
Based on record review and interview, the facility had failed to resubmit its emergency plan for further review and approval within the required 60 days upon receiving instructions to this effect.

Findings include:

A review of administrative documentation during the survey found a letter dated from the Pasco County Office of Emergency Management stating..."The plan does not contain the following required information which must be submitted...within 60 days of the date of this letter." Although the director of nursing/designee produced a letter of receipt from the emergency management office, no other documentation could be furnished verifying that the facility had resubmitted any evidence of corrections/compliance with the Pasco Office's request prior to the Agency's visit.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Zephyrhills Health & Rehabilitation Ctr
7350 Dairy Road
Zephyrhills, FL 33540

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2013, 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. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
(727) 552-2000; Fax (727) 552-1161