STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968261	05/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Coventry Assisted Living	415 N Wilder Rd Plant City, FL 33563	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A biennial state licensure survey was conducted on .

The Coventry assisted living facility had one deficiency found at the time of the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have personnel files which contained a free from communicable statement signed by a health care provider for two (#A & #B) of four staff sampled for free communicable statements.

Findings include:

Record review of staff #A personnel file on revealed there was no free from communicable statements signed by a health care provider. Staff #A had been hired on and she had thirty days to acquire the statement.

Record review of staff #B personnel file on revealed there was no free from communicable statements signed by a health care provider. Staff #B had been hired on and she had thirty days to acquire the statement.

When interviewed on at 2:30 p.m., the administrator confirmed there were no free from communicable statements in staff #A or staff #B's personnel files.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Coventry Assisted Living
415 N Wilder Rd
Plant City, FL 33563

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on . 2014, by representative(s) 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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Gaffman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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