STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911325	06/24/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Hpls Assisted Living Inc	300 East Kaley Avenue Orlando, FL 32806	
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

Specific Tag Findings:

0000-Initial Comments
Limited Nursing Services (LNS) monitoring was conducted on [redacted] HPLS Assisted Living Facility had a deficiency found during the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure 2 of 2 sampled staff (A & B) records contained a healthcare provider statement yearly, to indicate the staff did not have any signs or symptoms of [redacted]

Findings:

Individual personnel record review on [redacted] at approximately 2:30 PM revealed the following:

1. Staff A had a healthcare provider statement and a chest x ray dated [redacted] that indicated freedom from [redacted]

2. Staff B had a healthcare provider statement and chest x-ray that indicated freedom from [redacted] dated [redacted]

Continued individual personnel record review revealed no evidence to confirm the staff provided the facility with a healthcare provider statement that indicated freedom from [redacted] yearly thereafter (due 2014).

In an interview with the administrator on [redacted] at approximately 3 PM, she confirmed the findings and stated they both needed a [redacted] test or a [redacted] assessment.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
HPLS Assisted Living Inc
300 East Kaley Avenue
Orlando, FL 32806

RE: LNS monitoring

Dear Administrator:

This letter reports the findings of a state licensure LNS 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 deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies 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 Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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