STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965474	**09/15/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Wekiwa Springs	**203 S Wekiwa Springs Road Apopka, FL 32703**	
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

Initial Comments
The re-licensure Survey including Limited Nursing Services in conjunction with Complaint inspection CCR#2014005959 was conducted on [redacted] Emeritus at Wekiwa Springs Assisted Living Facility had deficiencies found at the time of the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure that 2 of 7 sampled staff (D and G), that were newly hired, had a statement that was completed by their health care provider that documented within 30 days of hire that they were free from communicable [redacted] and [redacted], and 2 of 7 sampled staff (Staff B, and C) had an annual [redacted] Test) from a health care provider.

Findings:

1. On [redacted] a personnel record review was completed for staff B. The record revealed that Staff B was hired on [redacted] Further review revealed no annual [redacted] test in the file, the last [redacted] test in the file was dated [redacted] Staff would have needed one on or before [redacted] and on or before [redacted] There was no evidence in the file that annual [redacted] tests were conducted.

2. On [redacted] a personnel record review was completed for staff C. The record revealed that staff C was hired [redacted] Further review revealed no annual [redacted] test in the file, the last [redacted] test in the file was dated [redacted] Staff would have needed one on or before [redacted] and [redacted] There was no evidence in the file that annual [redacted] tests were conducted.

3. On [redacted] a personnel record review was completed for staff D. The record review revealed that staff D was hired on [redacted] Further review revealed the [redacted] test dated [redacted] was signed by a CMA (Certified Medical Assistance), and was not completed by a health care provider (A physician or physician's assistant licensed under Chapter 458 or 459, F.S., or advanced registered nurse practitioner licensed under Chapter 464, F.S.). There was no documentation to review that indicated the healthcare provider signed the [redacted] test. Further review of staff D files showed no evidence that the employee had a Freedom from Communicable [redacted] statement from a healthcare provider in the file.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965474	**09/15/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Wekiwa Springs	**203 S Wekiwa Springs Road Apopka, FL 32703**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

4. On [redacted] a personnel record review was completed for staff G. The record revealed that Staff G was hired [redacted]. Further review revealed the [redacted] test in the file dated [redacted] was completed by a Licensed Practical Nurse (LPN) and was not completed by a health care provider (A physician or physician's assistant licensed under Chapter 458 or 459, F.S., or advanced registered nurse practitioner licensed under Chapter 464, F.S.)

On [redacted] at approximately 1:45 PM in an interview with the administrator he stated he has no other documents for the personnel files.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Emeritus At Wekiwa Springs
203 S Wekiwa Springs Road
Apopka, FL 32703

RE: Re-Licensure Survey with Limited Nursing Services (LNS)

Dear Administrator:

This letter reports the findings of a 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 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 407-420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

TDC:clr
Enclosure

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida