STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968468	02/17/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Victorian Manor Retirement Center Inc	4685 Chumuckla Hwy Pace, FL 32571	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0000-Initial Comments
An unannounced relicensure survey with Limited Nursing Services was conducted at Victorian Manor Assisted Living from to . Deficient practice was found at the time of the survey.

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on employee record review and interview with the facility Assistant Administrator, the facility failed to ensure 1 of 3 employees reviewed in the sample (employee "C") obtained a physician statement that the employee was free of communicable , including .

The findings are:

A record review was conducted for Employee "C". The employee date of hire is recorded as . The record review revealed that the employee received a signed statement of "Free of Communicable Statement", signed by a physician and test results dated . Also found in the record was a copy of a "NON-DOT Physical" indicating the employee obtained a physical examination on . Both the date of the Free of Communicable Statement, and the date of the NON-DOT Physical were not performed prior to the end of the 30 day period from date of hire requirement for the freedom from communicable , and the requirement for test results (end of the 30 day from hire was).

An interview was conducted with the assistant administrator on at approximately 3:45 p.m. The assistant administrator confirmed the findings and stated that she does not know why that happened, and that it does not make sense.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Victorian Manor Retirement Center Inc
4685 Chumuckla Hwy
Pace, FL 32571

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 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 me at (850) 412-4540.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosure
XG90

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