STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968107	**03/09/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
North Point Community Residential Facility Inc	**1937 College Cir N Jacksonville, FL 32209**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Limited Nursing Services (LNS) monitoring survey was conducted at North Point Community Residential Facility, Inc. in Jacksonville, Florida on , 2015. Deficiencies were identified as a result of the survey.

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on record review and staff interview, the facility failed to ensure that annual documentation of freedom from was available for review for 1 of 1 sampled employees. (Employee A)

The findings include:

A review of the personnel file for Employee A on revealed that there was no current documentation of screening available for review. Employee A (Owner/Administrator) had been the owner of the facility since Her most recent screening test was completed on , indicating that she was more than 2 years overdue for testing.

A interview at approximately 12:00 p.m. with Employee B, who was the only employee in the facility during the time of the survey, revealed that she had provided Employee A's personnel file for review, and that was all she had to provide. She stated she had no further information at that time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
North Point Community Residential Facility, Inc.
1937 College Circle North
Jacksonville, FL 32209

Dear Administrator:

This letter reports the findings of a state licensure Limited Nursing Services survey that was conducted on , 2015 by a representative 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. Should you have any questions please call this office at .

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure

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