

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/01/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968443	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 GEORGIA AVE ROCKLEDGE, FL 32955	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
0000 - Initial Comments The biennial re-licensure survey with Limited Mental Health Services was conducted on ____ Living Southern Style of Brevard had a 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 ensure personnel records for 1 of 4 sampled staff (Staff A) had freedom from ____ documented on an annual basis. Findings: Personnel record review was completed for Staff A. The review revealed she was hired _____. The Freedom from Communicable _____ statement from a healthcare provider in the record was dated _____. There is no update in the file. The statement would need to be updated by _____. On _____ at approximately 4:30 pm in an interview with the administrator she stated she did not have any updates. Class III		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Living Southern Style Of Brevard LLC
821 Georgia Ave
Rockledge, FL 32955

RE: Biennial relicensure w/LMH

Dear Administrator:

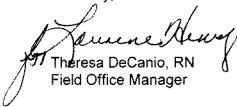
This letter reports the findings of a state licensure survey that was conducted on _____, 2015 by representative(s) of this office.

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 Lorraine Henry at _____.

Sincerely,


Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

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