

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 06/22/2015  
FORM APPROVED

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                     |
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| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUMBER:<br><br><b>AL11964869</b>                     | (X3) DATE SURVEY COMPLETED<br><br><b>06/11/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ZEPHYRHILLS HEALTH AND<br/>REHABILITATION CTR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>7350 DAIRY ROAD<br/>ZEPHYRHILLS, FL 33540</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                     |
| <p><b>0000 - Initial Comments</b></p> <p>Assisted Living Facility</p> <p>Zephyrhills Health and Rehab Center, Inc. had one deficiency found at the time of visit.</p> <p>A Biennial Survey in conjunction with re-visit to complaint CCR# 2015001050 conducted on / / .</p> <p><b>0085 - Training - Nutrition &amp; Food Service - 58A-5.0191(6) FAC</b></p> <p>Based on interview and record review the facility failed to ensure the administrator or person designated by the administrator as responsible for the facility's food service and day to day supervisor of food service staff obtained the required annually, minimum of 2 hours of continuing education.</p> <p>Finding Include:</p> <p>During a record review conducted on / / of the facility's personnel records, the facility did not provide evidence of minimum of 2 hours of continuing education, related to nutrition and food service for the food service designee.</p> <p>During an interview with the Food Service Manager on / / at 1:58 P.M., the Food Service Manager reviewed person file with the Surveyor and confirmed the findings. The Food Service Manager stated "I was not aware of such training, where can I get this type of training from?" The facility did not provide any further evidence at this time.</p> <p>Class III</p> |                                                                                               |                                                     |



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

\_\_\_\_\_, 2015

Administrator  
Zephyrhills Health And Rehabilitation Ctr.  
7350 Dairy Road  
Zephyrhills, FL 33540

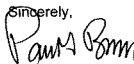
Dear Administrator:

This letter reports the findings of a Biennial 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. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,  


*for*

Patricia Reid Cauffman  
Field Office Manager

PRC/src  
Enclosure: State (5000-3547) Form

St. Petersburg Field Office  
525 Mirror Lake Drive North, Suite 410 A  
St. Petersburg, FL 33701  
Phone: (727) 552-2000; Fax: (727) 552-1162  
AHCA.MyFlorida.com



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