STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964869	**06/11/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
ZEPHYRHILLS HEALTH AND REHABILITATION CTR	**7350 DAIRY ROAD ZEPHYRHILLS, FL 33540**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

Zephyrhills Health and Rehab Center, Inc. had one deficiency found at the time of visit.

A Biennial Survey in conjunction with re-visit to complaint CCR# 2015001050 conducted on /

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

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.

Finding Include:

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.

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.

Class III

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 Caufman
Field Office Manager

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

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