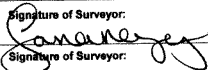


State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11965270	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/13/2015
Name of Facility MAGNOLIA MANOR OF PALM COAST,		Street Address, City, State, Zip Code 35 SANDS LANE PALM COAST, FL 32137

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0010</u> Reg. # <u>429.26(1&9) FS; 58A-5.018</u> LSC _____	Correction Completed	ID Prefix <u>A0032</u> Reg. # <u>58A-5.0182(8) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0082</u> Reg. # <u>58A-5.0191(3) FAC</u> LSC _____	Correction Completed
ID Prefix <u>AZ815</u> Reg. # <u>408.809, 435.02(2), 435.06</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: <u>11/20/15</u>	
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER MAGNOLIA MANOR OF PALM COAST,			STREET ADDRESS, CITY, STATE, ZIP CODE 35 SANDS LANE PALM COAST, FL 32137		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced follow-up to the licensure survey was conducted on 11/19/2015. Magnolia Manor had deficiencies found at the time of the visit.	{A 000}			
{A 078} SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials, shall satisfy the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of communicating 2. If any staff member has, or is suspected of having, a communicable disease, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their	{A 078}			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965270	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER MAGNOLIA MANOR OF PALM COAST,			STREET ADDRESS, CITY, STATE, ZIP CODE 35 SANDS LANE PALM COAST, FL 32137		
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{A 078}	Continued From page 1 assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) An assisted living facility contracting to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to Sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on employee record review, and staff interview, the facility failed to ensure that 1 out of 3 sampled employees (Employee C) received annual verification of freedom from Tuberculosis.	{A 078}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965270	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER MAGNOLIA MANOR OF PALM COAST,			STREET ADDRESS, CITY, STATE, ZIP CODE 35 SANDS LANE PALM COAST, FL 32137		
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{A 078}	Continued From page 2 The findings include: A review of file for Employee C revealed no documentation of a negative statement. The last X-Ray was performed in 2014. screenings are done yearly for employees. An interview was conducted with the Manager at 12:45 PM on . The Manger confirmed there was not an updated tuberculosis screen for Employee C. Class III	{A 078}			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Magnolia Manor Of Palm Coast,
35 Sands Lane
Palm Coast, FL 32137

Dear Administrator:

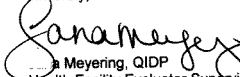
This letter reports the findings of a revisit survey conducted on , 2015 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2015.

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 (904) 798-4201.

Sincerely,


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

RS/JM/sm
Enclosure

BBT7

