STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966643	**11/20/2015**
NAME OF PROVIDER OR SUPPLIER **THERESA HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **485 MAPLE WAY SAFETY HARBOR, FL 34695**	

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

0000 Initial Comments

Assisted Living Facility Licensure

A biennial relicensure survey with Extended Congregate Care (ECC) was conducted at Theresa Home, Assisted Living Facility on . /_ . . . . Theresa Home, Assisted Living Facility, had a deficiency at the time of the visit.

0078 Staffing Standards - Staff

Based on interview and record review, the facility failed to maintain required documentation of an annual, examination for 1 (Staff C) of 3 records reviewed.

Findings Include:

An employee record review was conducted on . //_ . . . . . It was discovered that Staff B ' s last documented proof of an annual, examination (exam) occurred on // . . . .
An interview with the Administrator on //_ . . . . 1:20 P.M. confirmed Staff B provides direct care to residents at the facility. No further documentation was provided at this time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Theresa Home
485 Maple Way
Safety Harbor, FL 34695

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with extended congregate care (ECC) 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 attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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/clt
Enclosure: State (5000-3547) Form

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