STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965945	03/08/2016
NAME OF PROVIDER OR SUPPLIER **PALM TERRACE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **5121 EAST SERENA DRIVE** **TAMPA, FL 33617**	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2016002335) was conducted at Palm Terrace Assisted Living Facility and Adult Daycare Center on . Palm Terrace Assisted Living Facility and Adult Daycare Center had a deficiency at the time of the investigation.

0078 Staffing Standards - Staff

Based on record review and interview the Assisted Living Facility failed to ensure 1 of 3 sampled employees (Employee A) submitted a statement from a health care provider that the employee is free from communicable within 30 days of employment.

Findings Included:

A record review of Employee A ' s personnel file revealed that Employee A was hired on / . A health care statement dated / labeled . Testing for Employees showed that a ( ) test was provided to Employee A on / / and read by an Licensed Practical Nurse (LPN) on / . A statement below testing results read " The signature above verifies that the employee appears to be free of signs and symptoms of communicable and is physically fit for employment. "
A review of Florida Administrative Code 58A-5.0131(16) revealed the definition of a Health Care Provider as, " a physician or physician ' s assistant licensed under Chapter 458 or 459, F.S., or advanced nurse practitioner licensed under Chapter 463, F.S. "
During an interview with the Administrator on at 7:00 PM, the Administrator stated he believed that Employee A received a communicable statement and provided the statement signed by the LPN.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
Palm Terrace ALF
5121 East Serena Drive
Tampa, FL 33617

RE: CCR# 2016002335

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on [redacted], 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 [redacted], 2016.** 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 deficiency 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.

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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/kpr

Enclosure: State Form 5000-3547

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