RICK SCOTT
GOVERNOR

ELIZABETH DUDEK

12, 2016

Administrator
Forsyth House
5887 Berryhill Rd
Milton, FL 32570

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted 30, 2016 by representatives 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 12, 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 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965135	06/30/2016
NAME OF PROVIDER OR SUPPLIER **FORSYTH HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5887 BERRYHILL RD** **MILTON, FL 32570**	

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

0000 Initial Comments

An unannounced Biennial Abbreviated survey was conducted at Forsyth House Assisted Living Facility (License number 9549) on . At the time of survey deficient practice was identified.

0078 Staffing Standards - Staff

Based on record review and staff interviews, the facility failed to provide evidence of a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for 3 out of 7 sampled staff members (employees D, F and G)
The findings are as follows:
A review of employee files was conducted on at approximately 12:30 PM. A sample of 7 personnel records were examined to determine compliance for facility staffing standards. Employee files for staff members D, F and G did not contain the required statement from a health care provider that documents the individual does not have any signs or symptoms of communicable .
Class III