STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966623	**10/02/2017**
NAME OF PROVIDER OR SUPPLIER **STEPHANIE'S LOVE & CARE FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3056 W 1ST STREET** **JACKSONVILLE, FL 32254**	

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

0000 - Initial Comments

On , 2017 an unnanounced biennial assisted living facility relicensure survey with Limited Mental Health was conducted at Stephanies Love & Care Facility (License# 10793). Deficient practice was identified during the survey.

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on document review and staff interview the facility failed to provide evidence of a statement from a qualified health care provider indicating no signs or symptoms of a communicable . . . . . for 1 of 1 employee files reviewed. (employee A).

The findings Include:

The file for Employee A, with a hire date of , did not have a statement from a health care provider indicating freedom from communicable . . . . . .

During an interview with Employee A on at 1:00 PM she said was not able to find her statement of freedom from communicable . . . . . .

Class III