STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967203	**01/25/2018**
NAME OF PROVIDER OR SUPPLIER **IMMACULATE HOUSE AT COUNTRYSIDE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2542 COUNTRYSIDE PINES DRIVE** **CLEARWATER, FL 33761**	

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

0000 - Initial Comments

Assisted Living Facility

A biennial state licensure survey was conducted at Immaculate House at Countryside , (License # 11233), on . A deficiency was identified at the time of the visit.

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review the facility failed to ensure that one (A) out of three employees had a current negative test who worked in direct contact with residents in the facility.

Findings included:

On , an employee record review was completed. It was revealed that one employee did not have a current test completed.
Employee A had a hire date of . The employee's Communicable Provider Statement was reviewed. The section of the form entitled, New Associate included: The above named associate was examined on (blank space) and found to be free of signs or symptoms of a communicable including . Freedom from is evidenced by: A negative Mantoux ( ) skin test placed on and read on .
At approximately 4:30 pm, the Administrator stated that she did not have current statement for employee A.

Class III