STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911212	**04/11/2018**
NAME OF PROVIDER OR SUPPLIER **KELLY'S ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1441 - 1451 NW 20TH STREET** **FORT LAUDERDALE, FL 33311**	

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

0000 - Initial Comments

An unannounced abbreviated Relicensure survey was conducted on . . . . . at Kelly's Assisted Living Facility, License #5485. The facility had a deficiency at the time of the visit.

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

Based on interview and record review, it was determined the facility failed to ensure that each staff member submit a written statement from a health care provider documenting that the individual is free of signs or symptoms of communicable including ( ) annually, for 1 of 3 sampled staff records (Administrator)

The Findings Included:

During personnel record review with the Administrator on for the following staff member revealed the individual does not have documentation from a health care provider stating; that the individual does not have any signs or symptoms of communicable . . . . . , including . Last documentation by a health care provider dated .

The Administrator was present during the survey, acknowledged and confirmed the findings and no further documentation or information provided.

Class III