STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953416	R **02/27/2019**
NAME OF PROVIDER OR SUPPLIER **MAGNOLIA MANOR INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **926 S. MYRTLE AVENUE** **CLEARWATER, FL 34616**	

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

0000 - Initial Comments

Assisted Living Facility

A revisit to a . . . . . complaint survey was conducted on . . . . for Magnolia Manor Assisted Living.
At the time of the survey, the facility had deficient practice.

License 8539

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

Based on record review and interview the facility failed to ensure 1 of (A) 2 staff had evidence of an negative . . . . . examination documented on an annual basis.

Findings Included:

During review of staff records, it was revealed that Staff A's documentation of a negative . . . . . test expired on .
The acting administrator reviewed the employee's file on . . . . at 1:00pm and stated that she could not provide any additional documentation.

Class III