STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965700	**05/07/2019**
NAME OF PROVIDER OR SUPPLIER **MAPLE LEAF ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **24 MEAD PLACE** **STUART, FL 34997**	

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

0000 - Initial Comments

A biennial Relicensure survey was conducted on . . . . . at Maple Leaf Assisted Living Facility At Fisherman Cove Inc. The facility had a deficiency identified at the time of the survey.

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

Based on record review and a staff interview, the facility failed to ensure 1 out of 1 sampled employees (Staff A) had obtained an annual negative . . . . . ( ) statement by a health care provider.

The findings included:

During record review for Staff A, date of hire . . . . . , a signed statement by a health care provider, dated within the previous year, verifying that Staff A was free from could not be found.

A request was made to Staff A for the documentation on at 10:00 AM, but she was unable to locate this documentation at the time of survey. The facility provided no additional documentation for review at this time.

Class III