STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966350	05/15/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Dr Phillips Assisted Living Facility, Inc	5412 Palm Lake Circle Orlando, FL 32819	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments
Limited Nursing Services monitoring was conducted.

Dr. Phillips Assisted Living had a deficiency found during the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure the 2 of 2 sampled staff (A & B) provided the facility with a healthcare provider statement to indicate that the person did not have any signs or symptoms of .

Findings:

Personnel record review on at approximately 1 PM revealed that that staff #A had a test result dated .

Personnel record review on at approximately 1 PM revealed that that staff #B had a test result dated .

In an interview with the the administrator on at approximately 1 PM, she stated that they all needed a test; she would get hers next week, when she went to see her primary care provider.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Dr Phillips Assisted Living Facility, Inc
5412 Palm Lake Circle
Orlando, FL 32819

Dear Administrator:

Re: LNS monitoring

This letter reports the findings of a state licensure survey that was conducted on . 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . **2014,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

for Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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