STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963723	**01/02/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Chipola Health And Rehabilitation Center	**4294 Third Avenue Marianna, FL 32446**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0000-Initial Comments

On , 2015 an unannounced Extended Congregate Care (ECC) monitoring survey was conducted at Chipola Health and Rehabilitation Assisted Living Facility in Marianna, FL. Deficiencies were cited at the time of the survey.

0161-Records - Staff 58A-5.024(2) FAC
Based on record review and staff interview, the facility failed to provide proof of a communicable statement for 1 of 3 randomly sampled employees (staff B).

The findings:

On at approximately 11:10 a.m. a review of three randomly sampled employee files was conducted to determine regulatory compliance for staff providing Extended Congregate Care (ECC) services. Review of staff B personnel file indicated there was no communicable statement. At approximately 11:30 a.m. the Assistant Administrator was made aware of missing document and reported she would look through her training binder in an attempt to find the document.

On at approximately 12:12 p.m. an interview was conducted with the Assistant Administrator who reported, "I know she (staff B) had a communicable statement but we just cannot locate it at this time. I have looked through our training binder, her personnel file and her training file. I think it may have been misfiled but unfortunately I just cannot find it and I have searched through everything"

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Chipola Health And Rehabilitation Center
4294 Third Avenue
Marianna, FL 32446

Dear Administrator:

This letter reports the findings of an Extended Congregate Care monitoring survey that was conducted on , 2015 by a representative 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 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. Should you have any questions please call me at (850) 412-4540.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosure
XG90

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