

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964885</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JESUS HOME CARE, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3401 SW 72 COURT<br/>MIAMI, FL 33155</b>                                     |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 000                                                           | Initial Comments<br><br>A Complaint Survey (CCR#2013000139) was conducted on _____. Jesus Home had deficiencies found at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | A 000                                                                          |                                                                                                                          |  |                               |
| A 077<br>SS=D                                                   | 58A-5.019(1) FAC Staffing Standards -<br>Administrators<br><br>Staffing Standards.<br>(1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter.<br>(a) The administrators shall:<br>1. Be at least _____, 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after _____, 1995, must have a high school diploma or G.E.D.;<br>2. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and<br>3. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.<br>(b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate "manager" for each facility who must:<br>1. Be at least _____, and | A 077                                                                          |                                                                                                                          |  |                               |

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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483111

If continuation sheet 1 of 4

Agency for Health Care Administration

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| A 077                                                           | <p>Continued From page 1</p> <p>2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.<br/>(c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview facility's administrator failed to obtain evidence of High School Diploma or GED.</p> <p>Findings include:</p> <p>Record review for administrator (hired ) found no evidence of high school diploma or GED.</p> <p>Administrator acknowledged the findings on - at 2:00 pm</p> <p>Class III</p> | A 077                                                                          |                                                                                                                          |                          |                               |
| A 080<br>SS=D                                                   | <p>58A-5.0191(1) FAC Training - Core &amp; Competency Test</p> <p>Staff Training Requirements and Competency Test.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 080                                                                          |                                                                                                                          |                          |                               |

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| A 080                                                           | <p>Continued From page 2</p> <p>(1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.</p> <p>(a) The assisted living facility core training requirements established by the department pursuant to Section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.</p> <p>(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to _____, 1997, and managers who attended the core training program prior to _____, 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.</p> <p>(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S.</p> <p>(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:</p> <p>1. Retake the assisted living facility core training; and</p> |                                                                                | A 080                                                                                |                                                                                                                          |                               |

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| A 080                                                           | <p>Continued From page 3</p> <p>2. Retake and pass the competency test.<br/>(e) The fees for the competency test shall not exceed \$200. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview facility's administrator failed to obtain proof of passing the CORE competency test.</p> <p>Findings include:</p> <p>Record review for administrator ( hired ) found that he completed the 26 hours CORE training on . Further review revealed no evidence that he passed the CORE competency test.</p> <p>Administrator stated on at 2:00 pm that he passed the exam some time in 2006 but did not know where the proof of satisfactory passing score was.</p> <p>Class III</p> | A 080                                                                          |                                                                                                                          |                          |                               |



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

January 15, 2013

Administrator  
Jesus Home Care, Inc  
3401 Sw 72 Court  
Miami, FL 33155

Re: CCR #2013000139

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on January 15, 2013 by a representative(s) of this office.

Attached is the provider's copy of the State (3020) 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(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis  
Field Office Manager

AMD:sy  
Enclosure  
XG90

