

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 09/11/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11965694	(X3) DATE SURVEY COMPLETED 08/28/2013
NAME OF PROVIDER OR SUPPLIER Newport Home Care, Inc.	STREET ADDRESS, CITY, STATE, ZIP CODE 2811 Cleveland Street Hollywood, FL 33020	
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

An Assisted Living Facility standard biennial licensure survey was conducted on Newport Home Care, had licensure deficiencies found at the time of the visit.

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

Based on record review, the facility failed to ensure staff submit a statement from a health care provider that the person does not have any signs or symptoms of a communicable including for 3 out of 3 sampled employees (Employee A, B and C).

The findings are:

Record review of Employee A, B, and C file on revealed all employees provide direct care to residents. Further review revealed all files, lacked documentation from a health care provider verifying that they do not have any signs or symptoms of a communicable including

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Newport Home Care, Inc.
2811 Cleveland Street
Hollywood, FL 33020

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on _____, 2013 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 (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after _____, 2013 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager
Division of Health Quality Assurance

AMD
Enclosure

