STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953640	01/22/2014
NAME OF PROVIDER OR SUPPLIER **Hope Garden Assisted Living & Ecc, Inc**	STREET ADDRESS, CITY, STATE, ZIP CODE **2011 Nw 59th Way Lauderhill, FL 33319**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0030-Resident Care - Rights & Facility Procedures-01/22/2014
0081-Training - Staff In-Service-01/22/2014
0090-Training - 1/22/2014
Z815-Background Screening; Prohibited Offenses-01/22/2014

Revisit Repeat Tags:
0000-Initial Comments-
0079-Staffing Standards - Levels-58a-5.019(4) Fac

Specific Tag Findings:

0000-Initial Comments

A relicensure revisit survey was conducted on 01/22/14 at Hope Garden Assisted Living & ECC INC. The facility had an uncorrected deficiency.

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on observation and interview, the facility failed to ensure documentation of a written work schedule reflecting 24 hour weekly staff coverage meets the assisted living facility minimum staffing ratios for a census of 7.

The findings include:

A request was made on at 9:00 AM to the caregiver for the facility schedule. The schedule posted in the Administrator's office was dated The caregiver stated she did not know where the current schedule was located.

The caregiver contacted the Administrator who arrived at the facility at approximately 9:50 AM on During an interview with the Administrator/Owner regarding the schedule he provided (dated and a certificate for all employees he stated attended an inservice dated titled "completing accurate work schedule." The dates of the schedule were pointed out to the Administrator who became irate. The Administrator requested and was provided additional time to go through his files and office to locate a current staffing schedule but failed to do so during the survey.

The Administrator/Owner failed to provide a current schedule reflecting accurate staffing hours. The facility failed to have the required documentation of a work schedule reflecting 24 hour coverage that meets the assisted living facility minimum staffing ratios.

Uncorrected from
Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Hope Garden Assisted Living & ECC, Inc
2011 NW 59th Way
Lauderhill, FL 33319

RE: Relicensure Survey Revisit

Dear Administrator:

This letter reports the findings of a state relicensure survey revisit that was conducted on 22, 2014 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the previously cited deficiencies that were found corrected and the uncorrected deficiency that was identified during the revisit. 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 **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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure: State form 5000-3547

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