STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967753	04/08/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gomez Family Care Inc	2535 Nw North River Drive Miami, FL 33125	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Standard Biennial survey was conducted on 4/08/2014. Gomez Family Care Inc. Assisted Living Facility had deficiencies found at the time of the visit.

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

Based on record review and interview, the facility failed to obtain a statement from a health care provider indicating 1 out of 5 sampled staff did not have any signs or symptoms of a communicable including .

The findings included:

Personnel record review was conducted on at about 10:30 AM. revealed Staff C did not have documentation from a health care provider that he did not have any signs or symptoms of a communicable including .

Interview with Staff C on at approximately 12:30 PM revealed that he has been working in the facility for four months.

On at about 3:00 PM Staff B stated that there was no documentation from a health care provider that Staff C did not have any signs or symptoms of a communicable including .

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC

Based on observation, record review and interview the facility failed to have 1 out of 5 sample staff trained in nutrition and food handling (Staff C).

The findings include:

On at about 11:00 AM it was observed Staff C (caretaker) in the kitchen preparing food for lunch and later serving the food to residents.

Record review documented Staff C had no proof of being trained in nutrition and food handling.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967753	04/08/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gomez Family Care Inc	2535 Nw North River Drive Miami, FL 33125	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

Interview with Staff C on at approximately 12:30 PM revealed that he has been working in the facility for four months.

On at about 3:00 PM Staff B stated that the facility failed to have proof of nutrition and food handling training for Staff C.

Class III

0161-Records - Staff 58A-5.024(2) FAC

Based on records review and interview, the facility failed to ensure staff records contain a copy of the original employment application for 2 out of 5 facility staff (Staff A and C).

The findings include:

Personnel records review revealed that Staff A (administrator) and Staff C (caregiver) did not have a copy of the original employment application with references furnished.

On at about 3:30 PM Staff B confirmed that Staff A and C record did not have a copy of the original employment application with references completed and on file.

Class III

L243-LMH - Training 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to ensure 1 out of 5 (Staff B) received the required Limited Mental Health (LMH) training.

The findings include:

Record review for Staff B (facility caregiver, hired on) found no documentation of having received the limited mental health training.

On at about 3:30 PM Staff B stated that she had not taken the limited mental health training as required.

Class: III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Gomez Family Care Inc
2535 Nw North River Drive
Miami, FL 33125

Dear Administrator:

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 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,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121