STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968355	08/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A Casa Mango Assisted	6800 Mango Ave So Gulfport, FL 33707	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A biennial state licensure survey with limited nursing services (LNS) was conducted on .

A Casa Mango Assisted had a deficiency at the time of the visit.

0090-Training - 58A-5.0191(11) FAC

Based on employee file review and interview, 2 (staff A, and staff B) of 2 employee file review did not have have documentation indicating they received the training.

Findings include:

Employee file review for staff A revealed she was hired on . The file did not have any documentation of having completed the training.

During an interview on at approximately 11:12 a.m., staff A stated she was hired on to assist residents with personal care and medications.

Review of staff B employee file review revealed she was hired on . The file did not have any documentation of having completed the training.

During an interview on at approximately 1:30 p.m., staff B reported she stated she was hired in and was helping residents with their care.

The administrator was informed of the findings on at approximately 1:40 p.m. and stated she would ensure the training is done.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
A Casa Mango Assisted
6800 Mango Ave So
Gulfport, FL 33707

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with extended congregate care (ECC) 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid ..ufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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