STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966923	**03/20/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
I & G ASSISTED LIVING FACILITY, INC	**6560 HARBOUR ROAD NORTH LAUDERDALE, FL 33068**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on [redacted] at I & G Assisted Living Facility, Inc. The facility had a deficiency 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 ensure that 1 out of 3 sampled employees (Staff B), who provide direct care to residents, had an annual physician's statement documenting the employee was free from [redacted].

The Findings Include:

Employee record review revealed Staff B (hire date [redacted] did not have a current physician's statement indicating freedom from [redacted].

Staff B, a Home Health Aide, was observed touching Resident #3's shoulder while pushing her wheelchair to the dining [redacted] on [redacted] at 12:05 PM. In an interview conducted on [redacted] at 1:05 PM, Staff B stated she "usually" does not assist with administration of medication.

Staff B was observed on the written work schedule. In an interview conducted on [redacted] at 12:10 PM, the Administrator stated that Staff B does paperwork and does not provide direct care for residents. However, she counted Staff B's hours toward the total staffing hours for a given time period, thereby revealing that Staff B did provide direct care to residents. The Administrator then acknowledged the finding and stated no further documentation was available for review.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
I & G Assisted Living Facility, Inc
6560 Harbour Road
North Lauderdale, FL 33068

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on 2015 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 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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