STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965180	**05/01/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MAGGY'S HOME CARE	**8969 NW 152 LANE HIALEAH, FL 33016**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . Maggy's Home Care had the following deficiencies found at time of the survey:

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

Based on record review and interview the facility's personnel records did not include a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for one out of four (C.) sampled staff. The facility also failed to ensure that one out of four (C) complied with the training requirements.
Findings included:

Facility's record review revealed that sampled Staff C. (hire date /) employee's file did not include a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable with 30 days of employment.

On / at 2:45 PM Staff A. stated " She had to wait for the appointment at her doctor; she should have it done by the end of next week. "

Record review also found live in Staff (C.) did not have have First Aid and training documentation.

Staff C. stated on at 2:55 PM, I started the beginning of the last month." She also stated that she needed to finish the training.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Maggy's Home Care
8969 Nw 152 Lane
Hialeah, FL 33016

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on , 2015 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
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