STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965771	08/06/2015
NAME OF PROVIDER OR SUPPLIER **SAN JUDAS HOME CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **10720 NW 5 AVENUE** **MIAMI, FL 33168**	

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

0000 Initial Comments

An Abbreviated Biennial Survey was conducted on , 2015. San Judas Home Care Corp with Limited Nursing Services and Limited Mental Health components had the following deficiencies found at the time of survey:

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint in writing a separate manager for each facility, the facility's Administrator supervised more than one facility.

Findings included:

Record review of staff files revealed the facility did not have a manager's record. An interview search of the Florida heath finder website showed the Administrator supervised two assisted living facilities.

Interview of at 3:00 PM the Administrator stated "I have two facilities and I don't have a manager in them.

Class III

0079 Staffing Standards - Levels

Based on observations, record review, and interview the facility failed to maintain a written work schedule which reflects its 24 hour staffing period.

Findings included:

On at 9:00 AM the facility's staff schedule posted on the wall was for the month of 2015, it showed Staff B was not listed. Record review of the staffing schedule showed three staff members listed.

Interview on at 3:30 PM the Administrator acknowledged Staff B was not listed on the schedule.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015
Amended

Administrator
San Judas Home Care Corp
10720 Nw 5 Avenue
Miami, FL 33168

Dear Administrator:

This letter reports the findings of an Abbreviated 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

XG90

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