STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964643	08/24/2015
NAME OF PROVIDER OR SUPPLIER BISHOP CHRISTIAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1627 EAST 8TH STREET JACKSONVILLE, FL 32206	

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

0000 Initial Comments

An unnanounced biennial licensure survey with Limited Mental Health and Limi Nursing Services was conducted on - 24, 2015. Bishop Christian Home had licensure deficiencies found at the time of the visit.

0081 Training - Staff In-Service

Based on employee record review and staff interview, the facility failed to ensure that staff receive the required training within 30 days of employment for ADL (activities of daily living) and Behavioral Needs Training for 1 of 3 sampled employees (Employee C)

The findings include:

1) Employee C was hired on as a caregiver. A review of her training file revealed she did not have the required in-service f.. ADL and Behavioral Needs within 30 days of employment, or at any time since the date of hire.

2) During an interview with the assistant Administrator at 11:50 AM she confirmed Employee C has not received training for ADL and Behavioral Needs.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Bishop Christian Home
1627 East 8th Street
Jacksonville, FL 32206

Dear Administrator:

This letter reports the findings of a state biennial licensure with Limited Nursing Services and Limited Mental Health survey that was conducted on , 2015 by representatives 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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 surveyors. Should you have any questions please call this office at -4101.

Sincerely,

Jana Meyering, QHDP
Health Facility Evaluator Supervisor

JS/JM/sm
Enclosure
XG90

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone:(904) 798-4201; Fax:(904) 359-6054
AHCA.MyFlorida.com