STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967628	**09/21/2015**
NAME OF PROVIDER OR SUPPLIER **HAMMOCK MANOR, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3366 PENINSULA CIRCLE** **MELBOURNE, FL 32940**	

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

0000 Initial Comments

A complaint investigation (CCR 20015007075) was conducted at Hammock Manor, Inc. on I/ . Hammock Manor, Inc. had a deficiency found at the time of the investigation.

0079 Staffing Standards - Levels

Based on record review and interview the facility failed to ensure they had an up to date staff schedule.

Findings:

Observation on I/ at approximately 1:15 PM revealed Staff A was the only staff working in the facility. The census was 4.

Review of staff schedule for / / through I/ revealed staff A was scheduled for 24 hour shift and Staff B was scheduled to work from 7-1 PM on I/ . The staff schedule was not accurate.

In an interview with the administrator on I/ at approximately 2:10 PM who stated the staff schedule was not accurate. There was one 24 hour staff working and the facility had 4 residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Hammock Manor, Inc
3366 Peninsula Circle
Melbourne, FL 32940

RE: CCR #2015007075

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation 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 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 surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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