STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911036	11/24/2015
NAME OF PROVIDER OR SUPPLIER **CHARITY CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **461 EAST 31ST STREET** **HIALEAH, FL 33013**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on / . Charity Care Inc. with Limited Nursing Services and Limited Mental Health components had the following deficiencies found at time of the survey:

0081 Training - Staff In-Service

Based on record review and interview, the facility's personnel records did not include evidence of in-service training for one out of six sampled staff (Staff D).

Findings included:

Facility's record review on / revealed sampled Staff D (hire date /)'s file did not include evidence of in-service training on Assistance with Activities of Daily Living and Behavioral Needs training, Resident Rights, Recognizing / Reporting , Neglect & training.
On / at 2:17 PM the Administrator stated, " I will have Staff D complete the training."

Class III

0082 Training - /

Based on record review and interview, the facility failed to ensure one out of six sampled staff (Staff D) completed a course on and .

Findings included:

Facility's record review on / revealed sampled Staff D (hire date)'s file did not include documented evidence of / training.

On / at 2:17 PM the Administrator stated, "I will have Staff D complete the training."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Charity Care Inc
461 East 31st Street
Hialeah, FL 33013

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. **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 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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