

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 02/24/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964715	(X3) DATE SURVEY COMPLETED 02/10/2016
NAME OF PROVIDER OR SUPPLIER HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12810 SW 18 STREET MIAMI, FL 33175	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on Home Inc. with a standard license had the following deficiency at the time of the survey:

0085 Training - Nutrition & Food Service

Based on record review and interview the facility failed to ensure that one out three sampled staff (Staff B) had the required minimum of 2 hours of continuing education in nutrition and food service.

Findings included:

A review of the staff schedule found that Staff B was on duty.

At 10:30 am, Staff B was observed giving residents cookies and juice.

A review of the personnel record revealed that there was no documentation of Staff # B having the required two hours of continuing education in nutrition and food service.

On 2/10/16 at 1:00 PM the Administrator stated that she was aware of the finding and she would try to fix it as soon as possible.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Home Inc
12810 Sw 18 Street
Miami, FL 33175

Dear Administrator:

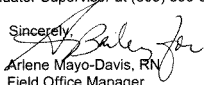
This letter reports the findings of a biennial state licensure survey that was conducted on
, 2016 by representative(s) of this office.

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 , 2016.** 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,


Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida