STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968883	07/26/2016
NAME OF PROVIDER OR SUPPLIER HOGAR, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8240 NW 171 ST MIAMI, FL 33015	

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

0000 Initial Comments

A Complaint (2016006435) Survey was completed on at Hogar Inc. with Limited Mental Health (LMH) components. There were deficiencies found at the time of the survey.(Lic #1270)

0078 Staffing Standards - Staff

Based on record review and interview the facility failed to have one out of three sampled employees' (C) written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable within 30 days of employment.

Findings included:

Record review revealed Employee C)started on . . . . The facility failed to have one Employee C's written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable within 30 days of employment.

Interviewed the Administrator on at 2:00 PM in regards to employee (C) not having the statement. The Administrator stated that Employee C shall be scheduled for her physical and testing as soon as possible.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview the facility failed to have one out of three sampled employees' (B) updated training for medication was completed within the last year.

Findings included:

Record review revealed Employee B last medication training was dated . The facility failed to have Employee B's updated training for medication annually.

Interviewed the Administrator on at 2:00 PM in regards to Employee B not having the up to date training in Assistance with Self-Administration of Medications.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

..., 2016

Administrator
... Hogar, Inc
8240 Nw 171 St
Miami, FL 33015
RE: CCR #2016006435

Dear Administrator:

This letter reports the findings of a Complaint 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 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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