STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965802	08/10/2016
NAME OF PROVIDER OR SUPPLIER **KSJ HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **67 EAST 56 TH STREET** **HIALEAH, FL 33013**	

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

0000 Initial Comments

A complaint inspection (CCR2016006531) was conducted on . KSJ Home Care Inc. (license #10135 with Standard license had the following deficiencies at the time of the visit:

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview the facility failed to respect 1 out of 5 (Resident #7) facility residents rights by not giving at least 45 days' notice of relocation or termination of residency from the facility .

Findings as follow:

Resident record review showed:

Resident #7 signed a Contract on / / with a Bed hold policy stating:
" The current bed-hold policy for this facility is 45 (Forty-five) days provided that the resident has paid for said month. This facility agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to a nursing home, health care facility or facility".
A Termination of Residency Policy saying: "The facility Administrator/Designee shall notify resident within 45 (forty-five) days written notice of termination of tenancy".
An Admission, Retention and Discharge Policy that states:
"At least 45 day- notice of relocation or termination of residency from the facility unless, for medical reason, the resident is certified by a physician to require an emergency relocation to facility providing more skilled level of care or the resident engages in pattern of conduct that is harmful or offensive to other resident who has been adjudicate mentally , the guardian shall be given 45 day- notice of Non-Emergency relocation or residency relocation or residency termination".

Record review showed the facility had no documentation of the 45-day Discharge policy given to resident.

at 11:25 a.m. the facility owner, stated:
Resident #7 was sent to the hospital on due to pain in the lower stomach. The resident remained in the hospital for several days. The owner stated that the resident was misbehaving and mistreating other residents so she decided to move resident out of facility without giving resident the 45-day discharge notice. She further stated that she talkked to another facility owner that had the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965802	08/10/2016
NAME OF PROVIDER OR SUPPLIER **KSJ HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **67 EAST 56 TH STREET** **HIALEAH, FL 33013**	

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

capacity in facility for a new resident. That owner picked up resident in the hospital and moved him to the new facility.

Class III

0079 Staffing Standards - Levels

Based on observation, record review and interview the facility failed to have an accurate Staffing schedule.

Findings as follow:

On at 11:05 a.m. Staff C and D were observed in facility working with a census of 6 residents.

Record review showed Staff D was not on the facility schedule.
Record review showed a Staff E , not working in facility, appeared on the schedule asStaff.

On at 1:16 p.m. the facility owner (Staff B) stated Staff E was not working in facility since the mid of . The owner recognized the Staffing schedule was not accurate.

Class III

0161 Records - Staff

Based on observation, record review and interview, the facility failed to have a an Employment application with references for 1 out of 4 (Staff D) facility Staff.

Findings as follow:

On at 11:05 a.m. Staff D was observed in facility working with a census of 6 residents.

Record review showed the fcaility failed to have an application for employment available for review for Staff D (hired a month earliergo).

On at 1:12 p.m. the facility owner (Staff B) acknowledged the facility had no application for employment for Staff D.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965802	**08/10/2016**
NAME OF PROVIDER OR SUPPLIER **KSJ HOME CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **67 EAST 56 TH STREET** **HIALEAH, FL 33013**	

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

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
Ksj Home Care Inc
67 East 56 Th Street
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on [redacted], 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 [redacted], 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