

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/25/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11912070	(X3) DATE SURVEY COMPLETED 04/13/2016
NAME OF PROVIDER OR SUPPLIER ALMOST HOME SENIOR SERVICES, I	STREET ADDRESS, CITY, STATE, ZIP CODE 9664 HOOD ROAD JACKSONVILLE, FL 32257	

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

0000 Initial Comments

On , 2016 a biennial licensure survey was conducted at Almost Home Senior Services. Deficient practice was identified during the survey.

0078 Staffing Standards - Staff

Based on document review and staff interview the facility failed to provide evidence of a statement from a qualified health care provider indicating no signs or symptoms of a communicable for 2 of 3 employee files reviewed. (Employees A & C).

The findings Include:

The file for Employee A, with a hire date // , did not have a statement from a health care provider indicating freedom from communicable

The file for Employee C, with a hire date of // did not have a statement from a health care provider indicating freedom from communicable

During an interview with the Administrator on at 2:15 PM she agreed that there was no documentation of freedom from communicable for Employee A or Employee B.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2016

Administrator
Almost Home Senior Services, Inc.
9664 Hood Road
Jacksonville, FL 32257

Dear Administrator:

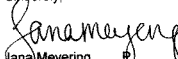
This letter reports the findings of a state licensure survey that was conducted on 2016 by a representative of this office.

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. Should you have any questions please call this office at 4201.

Sincerely,


Jana Meyering,
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JS/JM/sm
Enclosure
XG90

