STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967685	12/23/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Caring Hands Assisted Living Ii	13025 Nw 2 Avenue Miami, FL 33168	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0123 - 58a-5.021(2) Fac - Fiscal - Resident Trust Funds S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments

Acomplaint inspection (CCR #2014011795) survey was conducted on at your assisted living facility. There were discernible deficiencies found at the time of survey.

0123-Fiscal - Resident Trust Funds 58A-5.021(2) FAC

Based on record review facility failed to have any financial records to review during the complaint survey.

Findings includes

Record review on revealed the facility did not keep any of it's financial reports for the current year of 2014 for the residents monthly payments on site. The financial reports could not be examined because the facility owner/administrator kept them at another location.

Interview with the administrator by phone on at 10:30 am and 11:30 am he stated that he did not keep the financial log book at the facility and kept it at his office. He also stated that his business bank account was closed and had to be reopened because there had been a problem with the account from some fraudulent activity at the bank in which the business account had to be corrected.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure 2 out of 4 sampled residents have a signed consent form for being assisted with medications by an non-licensed staff member and no weights had been taken of residents when admitted to the facility.

Findings includes:

Record review of sampled residents # 3 (admitted on -) and #4 (admitted on -) showed the resident representatives did not have a signed consent for being assisted with medication by a non licensed staff. Further record review found resident #3 and #4 did not have any weights documented in thier file.

Interview with the administrator on by phone he confirmed the findings in regards to that residents #3 and #4 did not have their self-administration with medications paper work had been signed by their responsible parties with a Power of Attorney as well as documented weights.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967685	**12/23/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0167-Resident Contracts 58A-5.025 FAC

Based on record review and interview facility failed to have 2 out of 4 sampled residents to have a signed contract between the facility at time of admission.

Findings includes:

Record review of 2 sampled residents # 3 (admitted on -) and #4 (admitted on -) the resident did not have a contract between them and/or their representatives and the facility executed at admission.

Interview with the administrator on by phone he confirmed residents #3 and #4 did not have their contracts signed by the responsible parties.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Caring Hands Assisted Living Ii
13025 Nw 2 Avenue
Miami, FL 33168

RE: CCR #2014011795

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2014 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.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure 2014011795
XG90

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