STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965959	**01/29/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Adult Care Of Miami, Inc	**9833 Sw 27 Terrace Miami, FL 33165**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments

A Medicaid Program Integrity and Health Quality Assuarnce monitoring survey was conducted 01/29/15. Adult Care of Miami Assisted Living Facility (ALF) had no deficiencies found at time of survey

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 18, 2015

Administrator
Adult Care Of Miami, Inc
9833 Sw 27 Terrace
Miami, FL 33165

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on January 29, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the 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

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