STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965748	07/10/2015
NAME OF PROVIDER OR SUPPLIER **MABLEX HOME CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **13391 SW 27 ST** **MIAMI, FL 33175**	

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

0000 Initial Comments

An Abbreviated Biennial Survey was conducted on ,2015. Mablex Home Care had deficiencies found at time of survey.

0082 Training - / .

Based on record review and interview the facility failed to have one out of three (C.) sampled employees to trained in / .

Findings included:

1. Record review revealed that Employee C. (caretaker) hired on did not have any documentation of receiving training in / .

2. Interviewed the Administrator on - at 4:00 PM, she confirmed the finding in regards to Employee C. not having training in / since being employed at the facility.

Class III

0189 ADCCs in ALF

Based on record review and interview the facility failed to have completed health assessments for 2 out of 3 (#7 and #8) daycare participants. The facility failed to have documentation of a power of attorney (POA), surrogate, or guardian for 3 out of 3 (#6, #7, and #8) daycare participants.

Findings included:

1. Record review found the health assessments for Participants #7 and #8 were not completed. Record review also found the admission forms were completed and signed by family members/ friends for Participants #6, #7, and #8 without the facility having documentation of a POA, surrogate, or guardian.

2. Interviewed the Administrator on - at 4:00 PM, she confirmed the the health assessments was not completed , she confirmed the findings and stated that the form shall be completed by the doctor as soon as possible. She also acknowledged the facility did not have the required POAs.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Mablex Home Care
13391 Sw 27 St
Miami, FL 33175

Dear Administrator:

This letter reports the findings of an Abbreviated Biennial licensure survey that was conducted on , 2015 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 your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** 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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