STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967772	07/14/2015
NAME OF PROVIDER OR SUPPLIER **ABCARE ELDERLY SERVICES**	STREET ADDRESS, CITY, STATE, ZIP CODE **10450 SW 178 STREET** **MIAMI, FL 33196**	

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

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on , 2015. Abcare Elderly Services with Limited Mental Health and Limited Nursing Services components had the following deficiency found at time of survey.

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and interview, the Assisted Living Facility failed to have resident's consent to the use of full bed rail for one out of four sampled residents (#1).

Findings include:

Observation on at 11:05 AM revealed that resident #1 rested on bed in # with full bed rail up.

Record review of resident #1's file revealed that resident had a resident consent for the use of half-bed rail dated and signed on and a doctor order in record for full bed rail dated and signed on

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Abcare Elderly Services
10450 Sw 178 Street
Miami, FL 33196

Dear Administrator:

This letter reports the findings of a Standard Biennial 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Kristal Branton/se

Arlene Mauo-Davis, RN
Field Office Manager

AMD:kb
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