

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: [REDACTED]
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966387	(X3) DATE SURVEY COMPLETED R 07/29/2015
NAME OF PROVIDER OR SUPPLIER MARCIA ADULT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5143 SW 157 COURT MIAMI, FL 33185	

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

0000 Initial Comments

A limited nursing services monitoring revisit survey was conducted on [REDACTED], 2015. Marcia Adult Care with Limited [REDACTED] Health component did not have deficiencies found at time of survey.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

██████████, 2015

Administrator
Marcia Adult Care
5143 Sw 157 Court
Miami, FL 33185

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring survey revisit conducted on ██████████, 2015 by representative(s) of this office.

Attached is the provider's copy of the State Form (██████████), which indicates the previously cited deficiencies were found corrected on the day of the 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) ██████████.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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