STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953232	**07/31/2015**
NAME OF PROVIDER OR SUPPLIER **EBENEZER FAMILY HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **6690 WEST 14 AVENUE HIALEAH, FL 33012**	

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

0000 Initial Comments

A Complaint (CCR# 2015007099) Survey conducted on , 2015. Ebenezer Family Home Inc. had a deficiency found at the time of the visit.

0125 Fiscal - Suretv Bonds

Based on record review and interview facility failed to obtain a Surety Bond when signing and becoming a caretaker, guardian, Power Of Attorney and representative of a resident in their care at the facility at the time of the survey.

Findings included:

1. Record review revealed that Resident # 1 who is currently in Hospice care and doesn't have any other living relatives. The facility owner was named the resident POA and she did not at this time have a surety Bond on her Liability Insurance stating to have that action. The Liability Insurance Certificate dated - did not have a Surety Bond approval on it. Review of the POA second to the last page stated that the owner of the facility was appointed as the Guardian of resident #1 and the Durable Power of Attorney was dated on -.

2. Interview with the Administrator and the owner on -- at 4:00 PM , they both admitted that the owner was the POA for the Resident #1. The Owner stated that Resident #1 was a long time friend of the family and did not have anymore living family members, so she thought it was ok to become his guardian.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Ebenezer Family Home
6690 West 14 Avenue
Hialeah, FL 33012

RE: CCR #2015007099

Dear Administrator:

This letter reports the findings of a Complaint 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

XG90

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