STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966689	09/01/2015
NAME OF PROVIDER OR SUPPLIER **J C R ELDERLY CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **9760 MEMORIAL ROAD** **MIAMI, FL 33152**	

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

0000 Initial Comments

A complaint (CCR# 2015007625) survey was conducted on 1st, 2015. J C R Elderly Care Corp with Limited Nursing Services and Limited Mental Health component had the following deficiency found at time of survey.

0079 Staffing Standards - Levels

Based on observation and record review, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for the current period of time period.

Findings include:

Observation on / at 5:57 AM revealed that Caregiver A was in the facility.

Observation on / at 6:58 AM revealed that Caregiver B arrived to the facility.

In an interview with Caregiver A on / at 7:09 AM revealed that Caregiver A lived in.
In an interview with Caregiver B on / at 7:46 AM revealed that Caregiver B worked from 7 AM to 3 PM and had one day off but it was not a specific day.

Record review revealed that staff schedule posted in the bulletin board in the living staffing pattern for 2015- 2015.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
J C R Elderly Care Corp
9760 Memorial Road
Miami, FL 33152

RE: CCR #2015007625

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

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Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com