

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/05/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966576	(X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA'S CARE CENTER CORP #3	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 WEST 12 AVENUE HIALEAH, FL 33014	

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

0000 Initial Comments

On , 2015 a biennial relicensure survey was conducted at Carolina's Care Center Corp. #III Assisted Living Facility. Deficient practice was identified during the survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to hire manager to act in place of an administrator who supervises more then one facility.

Finding included:

During record review found Staff A. (Administrator) supervised two facilities. The facility did not have an appointed manager with the same qualifications as the Administrator on record.

On // and // , Staff A. confirmed they did not employ a manager .

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Carolina's Care Center Corp #3
8100 West 12 Avenue
Hialeah, FL 33014

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 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.shtm> 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

