| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968583 | 12/02/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**ALL CARE ALF INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**646 NW 129 PLACE**<br>**MIAMI, FL 33182** | |

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

**0000 Initial Comments**

A Standard Biennial Survey was conducted on _ _ _ _ _ _ _ _, 2015. All Care ALF Inc., with Limited Nursing Services and Limited Mental Health components had the following deficiencies found at time of the survey:

**0120 Fiscal - Financial Stabilitv**

Based on record review and interview the facility failed to have the last two months of income and expense records available to show evidence of financial stability.

Findings included:

Record review on revealed the facility did not have the income and expense records for the previous two months.

Interview on / at 10:30 am the Owner stated that she did not have the last two because she was waiting on the facility's accountant.

Class III

**0189 ADCCs in ALF**

Based on observation and interview facility failed to offer and provide activities to daycare participants.

Findings included:

Observation on / at 9:00 am found the facility had two daycare participants (7 and 8). The two participants (7 and 8) were sitting in the main TV. Observations on / at 2:00 pm found Participants #7 and 8 were still watching TV. The participants were not offered activities. Interview on / 1:00 pm Participants 7 and 8 stated, " We sit and watched TV."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
All Care Alf Inc
646 Nw 129 Place
Miami, FL 33182

Dear Administrator:

This letter reports the findings of a standard biennial licensure 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 , 2016.** 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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