STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966865	01/04/2016
NAME OF PROVIDER OR SUPPLIER **MERCY FAMILY CARE, INC #1**	STREET ADDRESS, CITY, STATE, ZIP CODE **4604 SW 144 COURT** **MIAMI, FL 33175**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on / and concluded on /. Mercy Family Care Inc #1 with Limited Mental Health component had the following deficiency found at the time of the survey:

0077 Staffing Standards - Administrators

Based on record review and interview facility failed to appoint a Manager for each facility.

Findings included:

On at 11:15 AM record review was revealed that the facility had appointed a Manager but it was the Administrator of another facility. The facility's Administrator supervised a total of three facilities.

Phone interview on / at 3:50 PM the Administrator stated that she was not aware of this new regulations and that she was going to put somebody as Manager in the facility as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

6, 2016

Administrator
Mercy Family Care, Inc #1
4604 Sw 144 Court
Miami, FL 33175

Dear Administrator:

This letter reports the findings of a standard biennial licensure survey that was conducted on , 2016 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

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