

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/03/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968092	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER VANGELA'S ALF CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 789 NW 145 TERRACE MIAMI, FL 33168	

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

0000 Initial Comments

A Standard Biennial Second Revisit Survey was conducted on 18, 2016 at Vangela's ALF Corp. with Limited Nursing Services component. A deficiency was identified.

0162 Records - Resident

Based on record review and interview the facility failed to provide a copy of documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for 2 out of 5 sampled residents (Resident #1 and #2).

Findings included:

Reviewed Resident #1's chart and found that all her documents had been signed by a family member. Record review of Resident #1's chart revealed that there was no documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for Resident #1. Interviewed the Owner of the facility on 11/11/16 at 11:30 AM, she confirmed the findings that Resident #1 did not have any of the documents needed in her chart for Health Care Surrogate, Health Care Proxy, Guardian or documentation for a Power of Attorney at the time of the survey. Record review revealed Resident #2 was admitted to the facility on 11/11/16. Resident #2's family member signed the contract without having a Power of Attorney, Surrogate, Proxy, or Guardianship documents in the resident's chart.

Interviewed the Owner of the facility on 11/11/16 at 1:00 PM, she stated that the daughter of the resident was told that a Power of Attorney, Surrogate, Proxy, or Guardianship was needed for anyone who has the responsibility of taking charge of a residents services at a facility. The family member has not done this yet for the facility.

Uncorrected

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968092	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
NAME OF FACILITY VANGELA'S ALF CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 789 NW 145 TERRACE MIAMI, FL 33168	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0030	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.0182(6) FAC, 429.28(1-2) FS	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>JS</i>	DATE 3/3/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/6/2015		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Vangela's Alf Corp
789 Nw 145 Terrace
Miami, FL 33168

Dear Administrator:

This letter reports the findings of a **second** Standard Biennial Licensure Revisit Survey conducted on , 18, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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

YOSF

