STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966115	R
NAME OF PROVIDER OR SUPPLIER **ANGELS FOREVER, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7201 SW 142 AVENUE** **MIAMI, FL 33183**	

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

0000 Initial Comments

A limited nursing services monitoring second revisit survey was conducted on , 2016. Angels Forever, Inc. with limited mental health and limited nursing services component had the following deficiencies identified at time of survey:

0008 Admissions - Health Assessment

Based on record review and interview, the Assisted Living Facility failed to have a completed health assessment 60 days prior to admission or 30 days after admission for two (#1 and #2) out of two sampled residents.

Findings included:

Review of Resident #1's filed revealed that Resident #1 admission date was on . Resident #1's Health assessment (AHCA 1823) was completed while the resident lived in previous facility on . Review of Resident #2's filed revealed that Resident #2 admission date was on . Resident #2's Health assessment (AHCA 1823) was completed while the resident lived in previous facility on . In an interview on at 2:13 PM the Administrator revealed that " Doctor office is going to send them to me. "

Class III
Uncorrected

0030 Resident Care - Rights & Facility Procedures

Based on observation and record review, the Assisted Living Facility failed to have a resident consent for the use of full-bed rail as well as to have a doctor order for the use of full-bed rail for two(#1 and #2) out of two sampled residents.

Findings included:

Observation on at 1:03 PM revealed that Resident #1 rested in bed with full bed side rail in # and Resident #2 rested in bed with full bed side rail in #.

Record review of Resident #1 ' s file revealed that there was a resident ' s consent to the use of half bed rail signed by Resident #1 ' s daughter on . There was a doctor order for full bed rails for safety measures and high risk for signed by hospice doctor.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966115	R
NAME OF PROVIDER OR SUPPLIER **ANGELS FOREVER, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7201 SW 142 AVENUE** **MIAMI, FL 33183**	

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

Record review of Resident #2 ' s file revealed that there was a resident ' s consent to the use of half bed rail signed by Resident #2 ' s daughter on . There was a doctor order for full bed rails for safety measures and high risk for signed by hospice doctor.

Class III
Uncorrected

Z813 Results of Screening & Notification in File

Based on record review and interview, the Assisted Living Facility failed to maintain the eligibility results of employee screening in the employee's personnel file for the Manager.

Findings included:

A review of the Manager's personnel file revealed that there was no documentation of an eligible Level II Background Screening.

A review of the Agency Health Care Administration background screening database revealed that the Manager background screening result was eligible dated .

In an interview on at 2:21 PM the Administrator revealed that " I checked all of the papers with the manager, I don ' t know how I missed those. "

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
AL11966115 Y1	Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS FOREVER, INC	7201 SW 142 AVENUE MIAMI, FL 33183

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 A0007 Reg. # 429.26(11) FS; 58A-5.0181(1) FAC LSC	Correction Completed	ID Prefix A0077 Reg. # 429.176 FS; 58A-5.019(1) FAC LSC	Correction Completed	ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
10/21/2015	

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Angels Forever, Inc
7201 Sw 142 Avenue
Miami, FL 33183

Dear Administrator:

This letter reports the findings of a **second** State 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo Davis, RN
Field Office Manager

AMD/sb
Enclosure

YOSF

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