STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963972	R 02/22/2016
NAME OF PROVIDER OR SUPPLIER **ROYAL OF KENDALL ACLF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **12201 SW 93 STREET** **MIAMI, FL 33186**	

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

0000 Initial Comments

A Complaint (CCR #2015007879) Second Survey Revisit conducted on 02/18/16 and concluded on 02/22/16. Royal of Kendall ACLF Inc had the following deficiency found at the time of the survey:

0162 Records - Resident

Based on observation, record review, and interview the facility failed have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for two out of three (#2 and #3) sampled residents.
Findings included:
Record review on / / found Resident #2's inform consent to provide assistance with medications by unlicensed personnel dated / was signed by Resident #2's daughter. The facility did not documentation of the appointment of a health care surrogate, health care proxy, guardian on record for review.
Review record Resident #3's informed consent to provide assistance with medications by unlicensed personnel dated and the resident's consent to the use of half bed rail dated were signed by Resident #3's daughter. The facility did not documentation of the appointment of a health care surrogate, health care proxy, guardian on record for review.
During a phone exit interview on / at 12:31 PM, the facility's Administrator stated I do not have a power of attorney for the Residents #2' and #3' for review.
Uncorrected Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Royal Of Kendall Aclf Inc
12201 Sw 93 Street
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a **second** Complaint Licensure Revisit Survey conducted on 22, 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 1, 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

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