STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953245	03/28/2016
NAME OF PROVIDER OR SUPPLIER **MOUNT SINAI HOME CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **21201 NE 13 PLACE** **NORTH MIAMI BEACH, FL 33179**	

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

0000 Initial Comments

An Abbreviated Biennial Survey was completed at Mount Sinai Home Care on - |- and concluded . There were deficiencies identified at the time of survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appointed manager for each facility, the Administrator supervised two facilities.

Findings included:

Record review revealed the facility's Administrator supervised two facilities and the facility failed to appointed Manager. Record review found the facility did not have a personnel record for a Manager.

Interviewed the Administrator by phone on at 3:00 PM, she stated that she did not have an appointed Manager for this facility at the time of survey but she did hire one after the survey.

Class III

Z814 Background Screening Clearinghouse

Based on record review and interview the facility failed to register staff members through the background screening's clearinghouse.

Findings included:

Record review revealed the facility did not register an staff members through the background screening's clearinghouse.

Interviewed the Administrator on - |- at 2:00 PM and she confirmed staff members were not registered at the time of survey

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Mount Sinai Home Care
21201 Ne 13 Place
North Miami Beach, FL 33179

Dear Administrator:

This letter reports the findings of an abbreviated 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

XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida