STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966253	03/10/2016
NAME OF PROVIDER OR SUPPLIER **A+ SENIOR HOME INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **41 SW 68 AVENUE** **MIAMI, FL 33144**	

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

0000 Initial Comments

A Complaint Investigation survey CCR# 2015012867 was conducted on .../.../... - .../.../... A+ Senior Home Inc with Limited Mental Health component had the following deficiency found at time of the survey:

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to provide documentation that the family members and health care provider were notified of changes in health status for six out of seven sampled residents (Resident #2, 3, 4, 5, 6 and 7).

Findings include:
On .../.../... at 1:00 PM, the Administrator stated "Resident #2 was admitted at the hospital on .../... and returned on .../... Resident #3 was admitted at the hospital on .../... Resident #4 was admitted at the hospital on ... Resident #5 was admitted at the hospital on ... Resident #6 was admitted at the hospital today. Resident #7 was admitted at the hospital on ..."
Record review showed that there was no documentation that the residents' family members and case managers were notified of these hospitalizations.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
A+ Senior Home Inc
41 Sw 68 Avenue
Miami, FL 33144

RE: CCR #2015012867

Dear Administrator:

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

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure 2015012867
XG90

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