STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942771	R
NAME OF PROVIDER OR SUPPLIER **CALUSA ADULT CARE I**	STREET ADDRESS, CITY, STATE, ZIP CODE **13871 SW 112 STREET** **MIAMI, FL 33186**	

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

0000 Initial Comments

A Biennial Revisit Survey was conducted on 04/05/16. Calusa Adult Care I had the following deficiencies at the time of the survey:

0167 Resident Contracts

Based on record review and interview, the facility failed to include a resident contract executed at or prior to admission for one out of five (#5) sampled residents.
Findings included:
Record review on AM showed that Resident #5, admitted on / / , did not have an executed contract with the facility.
On at 10:02 AM, the Administrator stated "I have the contract", however after a search, Resident #5's contract with the facility was not found.
Class II

Z814 Background Screening Clearinghouse

Based on observation, interview and record review, the facility failed to maintain an updated employee roster within the Agency for Health Care Administration's (AHCA) Background Screening Clearinghouse.
Finding included:
Reviewed the Agency for Health Care Administration Background Screening Clearinghouse database. No employee roster was found for the facility.
On at 12:35 PM, the Administrator acknowledged that there was no roster in the Clearinghouse database listing current facility staff, and stated that she called AHCA request assistance.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Calusa Adult Care I
13871 Sw 112 Street
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

BBT7

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