STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964612	04/28/2016
NAME OF PROVIDER OR SUPPLIER **MANULY'S ADULT CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **12710 NW 8 LANE** **MIAMI, FL 33182**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on . Manuly's Adult Care with a standard license had the following deficiencies found at the time of the survey:

0078 Staffing Standards - Staff

Based on record review and interview the facility's personnel records did not evidence of a negative examination documented on an annual basis for one out of four (Staff B) sampled staff.

Findings included:

On at 12:00 PM employee record review revealed sampled Staff B's last exam was dated . The facility's personnel records did not evidence of a negative examination documented on an annual basis for Staff B.

On at 1:00 PM the Administrator stated that he was not aware of this and that he was going to get it as soon as possible from the employee.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on observation, record review, and interview the facility failed to ensure one out of four (Staff B) sampled staff had 2/hours training for assistance with self-administration of medication.

Findings included:

On at 12:00 PM record review revealed Staff B did not have the continued training for assistance with self-administration of medication training. The initial was dated and expired .

On at 1:00 PM on an interview with administrator stated that he was not aware of this and that he was going to get it as soon as possible from the employee.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Manuly's Adult Care
12710 Nw 8 Lane
Miami, FL 33182

Dear Administrator:

This letter reports the findings of a Standard 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

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