

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/16/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932534	(X3) DATE SURVEY COMPLETED 05/05/2016
NAME OF PROVIDER OR SUPPLIER ESTHER HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13908 SW 26 TERRACE MIAMI, FL 33175	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on . Esther Home Care Inc. with Limited Mental Health component, had the following deficiency at the time of the visit:

0160 Records - Facility

Based on record review and interview the facility failed to have at least 2 elopement drills per year.

Findings as follow:

Record review documented the facility last elopement drill was preformed on .
On : at 11:56 a.m. Staff B acknowledge the facility failed to perform at least 2 elopement drills per year. adding the last elopement drill performed by facility was on .

Class III



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Esther Home Care Inc
13908 Sw 26 Terrace
Miami, FL 33175

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.shtm> 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
Field Office Manager

AMD/sb
Enclosure

XG90

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