STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966205	05/13/2016
NAME OF PROVIDER OR SUPPLIER CARE INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 11412 NW 1ST PLACE CORAL SPRINGS, FL 33071	

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

0000 Initial Comments

An unannounced relicensure survey was conducted on 05/13/2016 at Care Inc. The facility had deficiency identified at the time of the visit.

Z814 Background Screening Clearinghouse

Based on record review and interview, the facility failed to maintain an updated employee roster in the Clearing House, for 3 of 3 active employees (Employee A, B & C).

The findings include:

During record review on , it was noted that all three employees (Employee A, B & C) had a current background screening on file. Employee A had an eligibility date of , Employee B hired / had an eligibility date of and Employee C hired had an eligibility date of / . However, review of the clearing house employee roster on revealed that none of the employees were added to the facility's employee roster.

During an interview with the Administrator, she confirmed that she had not added her employees and herself to the clearing house roster.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
, Care Inc.
11412 NW 1st Place
Coral Springs, FL 33071

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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