

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/10/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967890	(X3) DATE SURVEY COMPLETED 05/27/2016
NAME OF PROVIDER OR SUPPLIER MARIA'S PALACE CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 1781-83 SW 4 STREET MIAMI, FL 33135	

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

0000 Initial Comments

An Abbreviated Survey was conducted on Maria's Palace Corp. (license #11860) had the following deficiency found at the time of the survey:

0162 Records - Resident

Based on record review and interview the facility failed to have completed and signed power of attorney (POA) forms for two out of eleven (#2 and #3) sampled residents.

Findings included:

Record review on showed Resident #2's inform consent to the use of bed rails dated / was signed by the resident's son, the POA dated was not signed. Further review found Resident #3's inform consent for the use of half bed rails dated signed by Resident #3's friend, POA was not signed.

During an interview on at 11:53 AM, the facility's Administrator acknowledged that POAs was not signed for Residents #2 and #3.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Maria's Palace Corp
1781-83 Sw 4 Street
Miami, FL 33135

Dear Administrator:

This letter reports the findings of an Abbreviated 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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