RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Abcare Elderly Services
10450 Sw 178 Ave
Miami, FL 33196

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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967772	R
NAME OF PROVIDER OR SUPPLIER **ABCARE ELDERLY SERVICES**	STREET ADDRESS, CITY, STATE, ZIP CODE **10450 SW 178 AVE** **MIAMI, FL 33196**	

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

0000 Initial Comments

A Complaint (CCR#2016007080) Survey Revisit was conducted on 09/22/2016. Abcare Elderly Services, License #11810, with Limited Mental Health and Limited Nursing Services had the following deficiencies identified at time of the survey.

0162 Records - Resident

Based on record review and interview the facility failed to have documentation of two out of four sampled residents (#2 and 4)'s proof of a power of attorney (POA), guardian, or surrogate documentation.

Findings included:

Record review on revealed Resident #2 & 4's son has been signing all of the documents in their file without having a POA, guardianship, or surrogate documentation.

Interview conducted on at 2:30 PM with the Administrator stated "I still don't have the power of attorney of Resident #2 and #4. I have been calling the residents' sons but they have not brought it yet."

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967772 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ABCARE ELDERLY SERVICES	10450 SW 178 AVE MIAMI, FL 33196

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0079	Correction	ID Prefix A0093	Correction	ID Prefix A0151	Correction
Reg. # 58A-5.019(3) FAC	Completed	Reg. # 58A-5.020(2) FAC	Completed	Reg. # 58A-5.023(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0181	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.026(2) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE 10/11/16	TITLE HFE3	DATE
FOLLOWUP TO SURVEY COMPLETED ON		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO