STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968494	**01/18/2017**
NAME OF PROVIDER OR SUPPLIER **MADELIN HOME CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **2980 SW 103 CT** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A Complaint (CCR# 2016014136) Survey was conducted on 18, 2017. Madelin Home Care Corp (License #112396) had the following deficiency identified in regards to this complaint.

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview the facility failed to notify the agency of a change in administrator within 10 days.

Findings include:

Record review found Staff B was listed as the administrator for the facility. Record review found Staff A was hired as the administrator on / / . Record review found the facility did not notify the agency of a change in administrator.

Interview on / at 10:50 AM Staff A stated, I am the Administrator. I sent Tallahassee the paperwork for the Change of Administrator. I am taking the CORE class now. I will be done in two weeks. Then I will take the test. "
Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Madelin Home Care Corp
2980 Sw 103 Ct
Miami, FL 33165
RE: CCR #2016014136

Dear Administrator:

This letter reports the findings of a Complaint licensure survey that was conducted on 18, 2017 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 , 2017.** 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

XG90

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