STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965959	**10/01/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Adult Care Of Miami, Inc	**9833 Sw 27 Terrace Miami, FL 33165**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Survey was conducted on . . . . . Adult Care of Miami, Inc. Assistaed Living Facility had the following deficiencies at time of the survey.

L243-LMH - Training 58A-5.0191(8) FAC

Based on record review and interview the facility failed to ensure that 2 out of 4 (B. & D.) employees' have received the minimum 6 hours limited mental health training or the 3 hours of Continuing Training in Limited Mental Health.

Findings include:

Record review on . . . . reviewed Staff B. (hire date . . . . and Staff D. (hire date . . . . employee file revealed no documentation of the initial Limited Mental Health Training.

On . . . . . at 10:50 AM, the administrator stated, " both employees are scheduled to go on . . . . . I ' ve scheduled them several times but every time I call for scheduling the classes are full. I am requesting the new license without the LMH specialty license. "

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Adult Care Of Miami, Inc
9833 Sw 27 Terrace
Miami, FL 33165

Dear Administrator:

This letter reports the findings of a standard biennial survey that was conducted on 2014 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.

Staff from this office will conduct a review after _____ to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure
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