

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint Investigation Survey (CCR# 2012005749) was conducted on _____ at Reyes Home Care. At the time of the survey, the following deficiencies were identified: A0007, A0025, A0030, A0160, A0167, and Z806 Census: 7	A 000		
A 007 SS-D	58A-5.0181(1) FAC Admissions - Criteria Admission Procedures, Appropriateness of Placement and Continued Residency Criteria. (1) ADMISSION CRITERIA. An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license: (a) Be at least _____ (b) Be free from signs and symptoms of any communicable _____ which is likely to be transmitted to other residents or staff; however, a person who has _____ () _____ may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule. (c) Be able to perform the activities of daily living, with supervision or assistance if necessary. (d) Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. (e) Be capable of taking his/her own medication with assistance from staff if necessary. 1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident ' s or the resident ' s	A 007		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

9009

ILT311

If continuation sheet 1 of 23

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 007	Continued From page 1 s surrogate, guardian, or attorney-in-fact ' s written informed consent to provide such assistance as required under Section 429.256, F.S. 2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident ' s legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident. (f) Any special dietary needs can be met by the facility. (g) Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapters 490 or 491, F.S. (h) Not require licensed professional mental health treatment on a 24-hour a day basis. (i) Not be bedridden. (j) Not have any _____ or 4 pressure sores. A resident requiring care of a _____ pressure may be admitted provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident ' s record; and 3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed nurse or physician, the resident shall be discharged from the facility. (k) Not require any of the following nursing services: 1. Oral, _____, or _____ suctioning; 2. Assistance with tube feeding; 3. Monitoring of _____ gases;	A 007			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 007	Continued From page 2 4. Intermittent positive pressure breathing ; or 5. Treatment of surgical _____ or wounds, unless the surgical _____ or _____ and the condition which caused it have been stabilized and a plan of care developed. (l) Not require 24-hour nursing supervision. (m) Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. (n) Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator shall base the decision on: 1. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule; 2. The facility ' s admission policy, and the services the facility is prepared to provide or arrange for to meet resident needs; and 3. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C. (o) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that 1 of 4 (resident #5) sampled residents met the minimum criteria in order to be admitted to an assisted living facility. Findings Include:	A 007		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 007	Continued From page 3 Observations on _____ at approximately 10:45 AM found resident #5 receiving _____ care in the living _____ Review review of resident #5 revealed that resident #5 needs total help with bathing, dressing, and self care (_____). In an interview with the administrator on at approximately 11:05 AM, she acknowledged the findings and stated that resident #5 is not a hospice patient. Class III	A 007			
A 025 SS=G	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 4 surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, resident record review, and interviews the assisted living facility failed to provide care and services and assess for change in condition for 1 out of 5 (resident #1) sampled residents who was admitted to the facility. The assisted living facility failed to have a written record, updated as needed, of any significant changes for 1 out of 5 (resident #5) sampled residents. Findings Include: Record review for resident #1 found resident #1 needs assistance with bathing. Record review revealed that on caretaker witnessed resident #1 forcefully hitting himself in the chest and abdomen and was pulling on his . Resident #1 remained at the facility and on : at approximately 8:30 AM, the caretaker informed the administrator about the incident which occurred the night before. Record review for resident #5 found no notes or documentation of resident #5 having a on her left ankle. In an interview with the caretaker on at approximately 9:23 AM, she stated she found	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 5 resident #1 in the living he was hitting himself in his chest and trying to rip his from his body. She stated he was kicking the glass sliding door while he was talking to his son on the phone. She stated after he spoke to the son he calmed down and asleep. She stated resident #1 ate breakfast and took a shower the following morning. In an interview with the administrator on at approximately 9:29 AM she stated she arrived to the facility on at about 8:00 AM. She stated that she called rescue for resident #1 at about 8:30 AM after she spoke to his doctor who advised her to send resident #1 to the hospital. In an interview with the nurse from a home health agency on at approximately 10:27 AM she stated that resident #5 had a on her left ankle since Observations on at approximately 10:45 AM found the nurse from a home health agency providing care to resident #5 in the living In an interview with the nurse from a home health agency on at approximately 10:42 AM, she stated she started coming for care on when it was a . She stated the is still a but is doing better. She stated the ordered is for daily care but next Thursday they will do an assessment with the doctor. In an interview with the administrator on at approximately 11:05 AM, she acknowledged the lack of documentation for resident #5 and stated the home health agency is currently keeping those residents.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 025	Continued From page 6 In an interview with the daughter of resident #1, on _____ at approximately 2:37 PM, she stated the morning of _____ her father was a little sleepy but that wasn't necessarily out of the norm. She stated the facility mentioned that he has been hitting himself in the area of his _____ and he cannot sleep at night. She stated she found _____ on his right side of his body when the facility told her that he was hitting himself on his left side. She stated that her father had _____ all over his arm and chest that it was almost black. She stated the night before her brother was called and the facility told him that the father was _____ and asked her brother to tell him to behave and go to sleep, which he did. She stated that she went over to the facility that morning because her brother told her about the incident. While she was there, her father's shirt was a little open and she was able to see to his chest. She stated his elbow was _____ and his arm was totally black. When rescue arrived, they took her father's shirt off and noticed even more _____. She stated that her father's _____ were also black. In an interview with the son of resident #1, on _____ at approximately 3:12 PM, he stated the night of _____ the caregiver called him and stated that his father was beating himself on the chest of the _____ side and he was sliding from the chair and falling and he was going to hurt himself and he spoke to him. He stated he told his father to behave himself and he begged his father to stop and the caregiver said he was getting _____. He stated the morning of _____ the caregiver warned him about the _____ on his arm and it was totally black from top to bottom. He stated his father's _____ were black and well as chest and arm.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 7	A 025		
A 030 SS=D	Class II 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida _____ Hotline " 1(800)96- _____ or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 8 pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical _____ shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical _____ 429.28 Resident bill of rights.-	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a _____ his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to respect residents rights in 2 of 7 (resident #5 and #6) facility residents. Findings Include: Observations on _____ at approximately 10:00 AM found resident #6 sitting in a reclining chair in the garage which was converted into a resident _____. Three beds were located in this converted _____ for resident use. In an interview with the administrator on _____ at approximately 10:01 AM, referring to the garage converted into a resident _____, she stated that one bed is occupied by resident #6 and the other two resident beds are currently empty. In an interview with a nurse from a home health agency on _____ at approximately 10:27 AM she stated that resident #5 had a _____ on her left ankle since _____. Observations on _____ at approximately 10:45 AM found the nurse from a home health agency providing _____ care to resident #5 in the living _____. Resident #5 was sitting in between other resident at the time _____ care was being provided. In an interview with the administrator on _____ at approximately 11:05 AM, she acknowledged the findings and stated they usually take resident #5 to her _____ care. In an interview with a nurse from a home health agency on _____ at approximately 11:09 AM	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 she stated she would sometimes do the care in the living it is quiet. Class III	A 030		
A 160 SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure ; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of . Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 160	Continued From page 13 (d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility's liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0182, F.A.C. (j) If the facility advertises that it provides special care for persons with _____ or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 14 served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer's license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years. (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility's resident elopement response policies and procedures. (r) The facility's documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to have an accurate and up today admission and discharge log. Findings Include: Record review found that resident #3 was current residing at the facility but was not listed on the	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 160	Continued From page 15 admission and discharge log. Record review found that resident #4 was currently present at the facility and listed on the admission and discharge log as a resident as admitted on Record review found that resident #6 was currently residing at the facility but was listed on the admission and discharge log as discharged on Record review found that resident #7 was current residing at the facility but was not listed on the admission and discharge log. In an interview with the administrator on at approximately 9:55 AM, she stated resident #4 is a day care resident; the daughter drops him off in the morning and picks him up around 6:00 PM. In an interview with the administrator on at approximately 11:05 AM, she acknowledged the findings that the facility's admission and discharge log is not up to date. Class III	A 160			
A 167 SS=D	58A-5.025(1) FAC Resident Contracts Resident Contracts. (1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services.	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 167	Continued From page 16 (b) The daily, weekly, or monthly rate. (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract. (d) A provision giving at least 30 days written notice prior to any rate increase. (e) Any rights, duties, or _____ of residents, other than those specified in Section 429.28, F.S. (f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments. (g) A refund policy which shall conform to Section 429.24(3), F.S. (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or _____ facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident ' s behalf. (i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility. (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident ' s representative, or agency acting on the resident ' s behalf, shall be notified in writing that	A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 167	Continued From page 17 the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect. (k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule. (l) The facility 's policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule. (m) The facility 's policies and procedures related to a properly executed This Statute or Rule is not met as evidenced by: Based on observation, resident record review, and interview facility failed to have signed contract for 1 out of 4 (resident #3) sampled resident. Findings Include: Observations on _____ at approximately 9:45 AM found resident #3 sitting on a chair in the living Record review found that resident #3's contract, which was dated and signed by the administrator	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 167	Continued From page 18 on _____, was not signed on behalf of resident #3. In an interview with the administrator on at approximately 11:05 AM, she acknowledged that the resident #3's contract was not signed by resident or guardian. Class III	A 167			
AZ806 SS=D	59A-35.040, FAC Change of Address (2) Any request to amend a license must be received by the Agency in advance of the requested effective date as detailed below. Requests to amend a license are not authorized until the license is issued. (a) Requests to change the address of record must be received by the Agency 60 to 120 days in advance of the requested effective date for the following provider types: 1. Birth Centers, as provided under Chapter 383, F.S.; 2. Abortion Clinics, as provided under Chapter 390, F.S.; 3. Crisis Stabilization Units, as provided under Parts I and of Chapter 394, F.S.; 4. Short Term Residential Treatment Units, as provided under Parts I and of Chapter 394, F.S. 5. Residential Treatment Facilities, as provided under Part of Chapter 394, F.S.; 6. Residential Treatment Centers for Children and Adolescents, as provided under Part of Chapter 394, F.S.; 7. Hospitals, as provided under Part I of Chapter 395, F.S.; 8. Ambulatory Surgical Centers, as provided under Part I of Chapter 395, F.S.; 9. Nursing Homes, as provided under Part II of	AZ806			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AZ806	Continued From page 19 Chapter 400, F.S.; 10. Hospices, as provided under Part of Chapter 400, F.S.; 11. Homes for Special Services as provided under Part V of Chapter 400, F.S.; 12. Transitional Living Facilities, as provided under Part V of Chapter 400, F.S.; 13. Prescribed Extended Care Centers, as provided under Part VI of Chapter 400, F.S.; 14. Intermediate Care Facilities for the as provided under Part VIII of Chapter 400, F.S.; 15. Assisted Living Facilities, as provided under Part I of Chapter 429, F.S.; 16. Adult Family-Care Homes, as provided under Part II of Chapter 429, F.S.; 17. Adult Day Care Centers, as provided under Part III of Chapter 429, F.S. (b) Requests to change the address of record must be received by the Agency 21 to 120 days in advance of the requested effective date for the following provider types: 1. Drug Free Workplace Laboratories as provided under Sections 112.0455 and 440.102, F.S.; 2. Mobile Surgical Facilities, as provided under Part I of Chapter 395, F.S.; 3. Health Care Risk Managers, as provided under Part I of Chapter 395, F.S.; 4. Home Health Agencies, as provided under Part III of Chapter 400, F.S.; 5. Nurse Registries, as provided under Part III of Chapter 400, F.S.; 6. Companion Services or Homemaker Services Providers, as provided under Part III of Chapter 400, F.S.; 7. Home Medical Equipment Providers, as provided under Part VII of Chapter 400, F.S.; 8. Health Care Services Pools, as provided under Part IX of Chapter 400, F.S.; 9. Health Care Clinics, as provided under Part X	AZ806		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AZ806	Continued From page 20 of Chapter 400, F.S., including certificate of exemption; 10. Clinical Laboratories, as provided under Part I of Chapter 483, F.S.; 11. Health Testing Centers, as provided under Part II of Chapter 483, F.S.; 12. Organ and Tissue Procurement Agencies, as provided under Chapter 381, F.S. (c) All other requests to amend a license including but not limited to services, licensed capacity, and other specifications which are required to be displayed on the license by authorizing statutes or applicable rules must be received by the Agency 60 to 120 days in advance of the requested effective date. This deadline does not apply to a request to amend hospital emergency services defined in Section 395.1041(2), F.S. (3) Failure to submit a timely request shall result in a \$500 fine. (4) A licensee is not authorized to operate in a new location until a license is obtained which specifies the new location. Failure to amend a license prior to a change of the address of record constitutes unlicensed activity. (5) The licensee shall return the license certificate to the Agency upon the rendition of a final order revoking, cancelling or denying a license, and upon the voluntary discontinuance of operation. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the assisted living facility failed to submit to the Agency 60 to 120 days in advance a request modify the licensed capacity. The facility exceeded the licensed capacity of 6 beds.	AZ806		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AZ806	Continued From page 21 Findings Include: Observations on _____ at approximately 9:45 AM found seven residents currently present at the facility. Resident #7 was found watching television on _____. Resident #3, resident #5, resident #8, resident #4, and resident #9 were sitting left to right in the living _____ separate chairs. Resident #6 was sitting in a reclining chair in the garage which was converted into a resident _____. In an interview with the administrator on _____ at approximately 9:50 AM, she stated that resident #2 is a current resident of the facility but is with her son now. In an interview with the administrator on _____ at approximately 9:55 AM, she stated resident #4 is a day care resident; the daughter drops him off in the morning and picks him up around 6:00 PM. In an interview with the daughter of resident #4 on _____ at approximately 10:04 AM, she confirmed that she drops her father off at the facility in the morning and picks him up at night. She stated she likes the care that the facility provides and plans on her father being a resident in the future. Record review found resident #4 was listed on the facility's admission and discharge log and had a signed resident contract dated _____. In an interview with the administrator on _____ at approximately 10:21 AM, she made a list of all current residents and confirmed the facility is currently exceeding its capacity of six.	AZ806		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SW 103 COURT MIAMI, FL 33174			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
AZ806	Continued From page 22 Class III	AZ806			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Reyes Home Care
1111 Sw 103 Court
Miami, FL 33174

Re: CCR #2012005749

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) 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
Field Office Manager

AMD:sy
Enclosure
XG90

