

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 04/04/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967113	(X3) DATE SURVEY COMPLETED 03/10/2014
NAME OF PROVIDER OR SUPPLIER Reyes Home Care #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 Sw 83 Court Miami, FL 33155	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Standard Biennial survey was conducted on . Reyes Home Care #2 Assisted Living Facility Home had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on observation, record review and interview the facility failed to obtain an up to date health assessment (1823) form for 1 out of 2 sampled residents (Resident #1).

The findings include:

Observation on . at about 12:00 PM revealed that Residents #1 a received puree diet.

Record review for Resident #1 found that she was admitted to the facility on . Record review of Resident ' s #1 health assessment completed on . found that the resident had has sacral and a no added salt diet.

Resident #1 health assessment did not include that the sacral healed and the resident receives puree diet.

Interview conducted with the facility administrator on . at about 2:00 PM confirmed that Resident #1 receives puree diet and the sacral healed few months ago.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Reyes Home Care #2
1640 Sw 83 Court
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a state licensure 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
Field Office Manager

AMD:sy
Enclosure
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