

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 11/29/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966265	(X3) DATE SURVEY COMPLETED R 11/22/2016
NAME OF PROVIDER OR SUPPLIER BUENA VISTA HEALTH CARE II, CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 7968 W 14 COURT HIALEAH, FL 33014	

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

0000 Initial Comments

A Change of Ownership (CHOW) Revisit Survey was conducted on November 22, 2016. Buena Vista Health Care II, Corp had no deficiencies identified at time of the survey.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11966265	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/22/2016
NAME OF FACILITY BUENA VISTA HEALTH CARE II, CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 7968 W 14 COURT HIALEAH, FL 33014	

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 A0078	Correction	ID Prefix A0079	Correction	ID Prefix AZ814	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.019(3) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed
LSC	11/22/2016	LSC	11/22/2016	LSC	11/22/2016
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	
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	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 29, 2016

Administrator
Buena Vista Health Care II, Corp
7968 W 14 Court
Hialeah, FL 33014

Dear Administrator:

This letter reports the findings of a change of ownership survey revisit conducted on November 22, 2016 by representative(s) of this office.

Attached is the provider's copy of the State Form, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 Sonia A Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD:SB
Enclosure

DT9D

