

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967411	(X3) DATE SURVEY COMPLETED 08/12/2014
NAME OF PROVIDER OR SUPPLIER Dios Da El Mana Corp	STREET ADDRESS, CITY, STATE, ZIP CODE 9980 Sw 1 Street Miami, FL 33174	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments

A Biennial Standard survey was conducted on _____, 2014. The facility had deficiencies at the time of survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and interview, the facility failed to ensure 1 out of 6 residents sampled (Resident #2) to have documented a doctor's order and resident consent for the use of half bedrails.

Findings include:

Observation on 8/12/14 at 9:00 am revealed, resident #2 had a 1/2 bed rail in room 101.

Resident record review on 8/12/14 at 9:10 am, for resident #2 revealed that she did not have a doctor's order and/or a signed resident consent for the use of 1/2 bed rails.

Interview on 8/12/14 at 11:00 am with the administrator and staff A revealed, they did not have a doctor's order and/or a signed resident consent for the use of 1/2 bed rails.

Class III



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Dios Da El Mana Corp
9980 SW 1st Street
Miami, FL 33174

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 at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis
Arlene Mayo-Davis
Field Office Manager

amd
Enclosure

XG90

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