STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965384	01/14/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Exclusive Home	183 West 18 Street Hialeah, FL 33010	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on , 2015. Exclusive Home had a deficiency at time of survey.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on record review and interview facility failed to discharge a resident that does not longer meets the continuous residency criteria for 1 out of 4 sampled residents (# 4). Facility also failed to conduct a new face-to-face medical examination after a significant change for 1 out of 4 sampled residents (#4).

Findings included:

On , 2015 at 9:05 am, the caregiver was observed bringing resident #4 from the a wheelchair. She put a portable table in front of the resident and started feeding resident a yogurt. Resident was not able to follow verbal prompting to feed herself.

On , 2015 at 9:10 am, the caregiver stated "We do everything for her [Resident #4]. She is not able to walk or transfer. She is totally . Sometimes she is able to feed herself but most of the time we feed her."

Record review revealed that last health assessment was conducted on and resident required assistance with activities of daily living, but did not specified what type of assistance.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Exclusive Home
183 West 18 Street
Hialeah, FL 33010

Dear Administrator:

This letter reports the findings of a limited nursing services monitoring survey that was conducted on , 2015 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
XG90

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