

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/31/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965276	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER B & B HOME CARE 1, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 20625 SW 114 PLACE MIAMI, FL 33189	

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

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on , 2015. B & B Home Care 1, Inc with Limited Nursing Services and Limited Mental Health components had the following deficiency found at time of survey.

0078 Staffing Standards - Staff

Based on record review and interview, the Assisted Living Facility failed to have a written statement from a health care provider documenting that the Registered Nurse did not have any signs or symptoms of communicable as well as to have evidence of a negative examination on an annual basis for registered nurse.

Findings include:

Record review of registered nurse's personal file revealed that there was not a written statement from a health care provider documenting that Registered Nurse did not have any signs or symptoms of communicable neither evidence of a negative examination on an annual basis for the Registered Nurse.

Interview with registered nurse on at 2:19 PM revealed that she made copy of the physical examination and it was supposed to be there.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

B & B Home Care 1, Inc
20625 Sw 114 Place
Miami, FL 33189

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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than - , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida