STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910878	**08/12/2015**
NAME OF PROVIDER OR SUPPLIER **BLUE SKY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **354 SW 22ND ROAD** **MIAMI, FL 33129**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2015. Blue Sky Inc with Limited Mental Health (LMH) component had the following deficiencies found at time of the survey:

Z824 Right of Inspection: inspection reports

Based on interview the facility failed to give the agency (AHCA) access to conduct a standard biennial.

Findings included:

The surveyor knocked on the door several times on / / at 9:30 AM. The person who opened the door stated "I will contact the owner of the house because we were renting the property. This is not an ALF anymore. You could sit outside and wait for the owner. He will give you more information." Interview conducted with the facility owner at 11:10 AM stated "I contacted Tallahassee because the facility is no longer operational and has been closed without residents since / . I closed the facility because I have been very sick. I can not allow you to have access to the facility because I am renting the property. I will fax to your office the email that I received from Tallahassee and the voluntary closure letter."

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Blue Sky Inc
354 Sw 22nd Road
Miami, FL 33129

Dear Administrator:

This letter reports the findings of a Standard Biennial 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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,

Kristal Branton /gz

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

XG90

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