STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965986	**10/01/2015**
NAME OF PROVIDER OR SUPPLIER **IZQUIERDO HOME CARE I**	STREET ADDRESS, CITY, STATE, ZIP CODE **311 SW 62 AVE MIAMI, FL 33144**	

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

0000 Initial Comments

A Complaint Survey (CCR#2015008281) was conducted on , 2015. Izquierdo Home Care I with Limited Mental Health component had deficiencies identified at time of survey.

0010 Admissions - Continued Residency

Based on record review and interview facility failed to conduct a face to face medical examination by a health care provider as part of the continued residency criteria after a significant change for 3 out of 4 sampled residents (Residents # 1, # 2 and # 3).

Findings included:

Record review of Resident # 1 revealed that the last health assessment was completed on and stated that resident required assistance with ambulation and dressing, total assistance with bathing; was independent with eating and and required assistance with toileting and transfer. At this time resident is able to stand up and help with transfer, but he is not able to walk; continues to be independent with eating and ; he is continent of and feces and only requires assistance to use the ; resident is able to assist with bathing by using the sponge to apply soap to his body and is also able to assist with dressing.

Record review of Resident # 2 revealed that last health assessment was completed on and states that resident requires assistance with her activities of daily living; at this time resident requires total assistance with dressing, and toileting and assistance with the rest of her activities of daily living.

Record review of Resident # 3 revealed that last health assessment was completed on and states that resident requires assistance with her activities of daily living; at this time resident requires total assistance with dressing, and toileting and assistance with the rest of her activities of daily living.

During the exit conference on / at 11:40 am, the facility owner/administrator stated that she will contact the doctor today to tell her that residents # 1, # 2 and # 3 needs a new health assessments.

Class III

0030 Resident Care - Rights & Facility Procedures

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

Based on record review and interview facility failed to honor residents rights regarding the use of side rails for 2 out of 4 sampled residents (Residents # 2 and # 3).

Findings included:

Record review of residents # 2 and # 3 revealed that the last prescription for use of half side rail was written by their doctor on / .

During exit conference on / at 11:40 am, the facility owner/administrator stated that she will contact the doctor today to get a new prescriptions for half side rail for the residents because she did not realize that a year had already passed since last prescription.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Izquierdo Home Care I
311 Sw 62 Ave
Miami, FL 3314

RE: CCR #2015008281

Dear Administrator:

This letter reports the findings of a Complaint 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,

Arlene Mayo-Davis, RN
Field Office Management

AMD:kb
Enclosure

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