STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966651	10/29/2015
NAME OF PROVIDER OR SUPPLIER **RENACER HOME CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **644 642 SE 4 PLACE** **HIALEAH, FL 33010**	

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. Renacer Home Care with Limited Nursing Services and Limited Mental Health components had a deficiency identified at time of survey.

0007 Admissions - Criteria

Based on observation, record review, and interview the facility failed to ensure that 1 out of 2 sampled residents (#1) met admission criteria. Resident #1 required total care at the time of admission.

Findings included:

During tour of the facility on at 8:40 am observed Resident #1 lying in the bed in # , the resident's arms and legs were observed to be contracted.

Review of admission and discharged log revealed that Resident #1 was admitted to facility on . The log revealed that Resident #1 used to live in the facility from / to / and that she went home with hospice services. Record review revealed that Resident #1 has been receiving hospice services since / / with a diagnosis of .

Caregiver A stated on at 9:00 am that Resident # 1 required total assistance with her activities of daily living.

The facility's Administrator stated on at 9:25 am that he thought that since the resident used to live in the facility before it was no problem to re-admit her. He stated that he will contact the family to let them know that the resident needs to be taken back home.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Renacer Home Care
644 642 Se 4 Place
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. **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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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