AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967143	11/17/2015
NAME OF PROVIDER OR SUPPLIER **GONZALEZ & SONS HOME CARE INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **4290 SW 4 STREET** **MIAMI, FL 33134**	

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

0000 Initial Comments

An Abbreviated Biennial Survey was conducted on [redacted], 2015. Gonzalez & Sons Home Care Inc. II with a Limited Mental Health component had the following deficiency identified at the time of the survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint in writing a separate manager for each facility, the facility's Administrator supervised more than one facility.

Findings included:

On / / at 10:45 AM during record review was revealed that the Facility had not appointed a Manager for this facility. An Internet search of the Florida heath finder website showed the Administrator supervised two assisted living facilities.

On / / at 12:45 PM during an interview with the administrator he stated that he was not aware of this new regulations and that he was going to put somebody as Manager in the facility as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2015

Administrator
Gonzalez & Sons Home Care Inc Ii
4290 Sw 4 Street
Miami, FL 33134

Dear Administrator:

This letter reports the findings of a Abbreviated 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,

Arlene Mayo-Davis, RN
Field Office Manager

jcj
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