STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968533	11/05/2015
NAME OF PROVIDER OR SUPPLIER **DAVISITOS 2 INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13701 SW 71 LANE** **MIAMI, FL 33183**	

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

0000 Initial Comments

A Complaint Investigation (CCR# 2015010816) was conducted on / - / . Davisitos 2 Inc. had the following deficiencies identified at time of the survey.

0030 Resident Care - Rights & Facility Procedures

Based on interviews and record review, the facility failed to honor the rights of one of six residents (Resident #1) by not honoring a Power of Attorney authorized by the resident and by prohibiting Resident # 1 from having unrestricted visits with two of her children.

Findings:

On / / at approximately 8:50 a.m., Family Member #1 stated that he had told the Administrator that " none of those people " were allowed to visit his Resident #1, referring to his brother, his sister and his uncle.

Record review revealed a letter from Family Member #1 asking that his brother and sister be restricted from visiting their mother.

Record Review revealed a Power of Attorney (POA) form dated , 2014 naming Family Member # 1 as POA. The record also revealed a second POA form dated , 2015, naming Family Member #2 as POA.

On / / at 11:30 am, Resident #1 stated that she had requested and signed the second POA dated , 2015, authorizing Family Member #2 to act on her behalf. She stated that Family Member #1 had obtained the original POA dated , 2014, against her wishes.

Record review revealed a note in Resident #1's file dated stating that Family Member #2 came by, but the facility owner wouldn ' t let him in because he wasn ' t authorized by Family Member #1.

On / / at 9:45 am, the facility Owner stated that the facility believed Family Member #2 had falsified the POA dated , 2015 in an attempt to remove Resident #1. He further stated that he would not allow this, and that he had called Family Member #1 to report it.

On / / at approximately 10:00 am, Family member #2 stated that he was not allowed to come over since last year because of Family Member #1.

On / / at approximately 11:30 am, Resident #1 stated " they won ' t let my son [Family Member #2] visit me here. Sometimes they won ' t even let my daughter inside. "

On / / at approximately 1:00 pm, the Administrator stated that she didn ' t allow Family Member #2 to visit because Family Member #1 said he couldn ' t.

On / / at approximately 1:15 pm, Family Member #3 stated that when she came to the facility one day in , the facility staff didn ' t want to let her in, so she and Resident #1 met briefly outside.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968533	**11/05/2015**
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Davisitos 2 Inc
13701 Sw 71 Lane
Miami, FL 33183

RE: CCR #2015010816

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 Manager

AMD:kb
Enclosure

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