| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11942793 | 03/09/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**LA MILAGROSA HOME** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**3341 SW 7 STREET**<br>**MIAMI, FL 33135** | |

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

**0000 Initial Comments**

A Standard Biennial Survey was made on . La Milagrosa Home Care Inc had the following deficiency at the time of the visit:

**0162 Records - Resident**

Based on record review and interview, the facility failed to maintain documentation of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for 1 of 2 facility residents (Resident #1).

Findings:

A review of the resident record showed that Resident's #1 Contract was signed by a family member.

A review of the resident record showed that there was no record of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for Resident #1.

On at 12:35 p.m. the Administrator stated resident #1's contract was signed by a family member and acknowledged that the facility had no documentation of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for resident #1, available for review.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

....., 2016

Administrator
La Milagrosa Home
3341 Sw 7 Street
Miami, FL 33135

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on 9, 2016 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 , 2016.** 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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