STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911679	**05/19/2016**
NAME OF PROVIDER OR SUPPLIER **HOME MERCEDES, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6355 SW 2ND STREET** **MIAMI, FL 33144**	

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

0000 Initial Comments

A Change of Ownership Survey was conducted on 05/19/16. Home Mercedes, Inc with Limited Mental Health components had no deficiencies found at the time of the survey.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 31, 2016

Administrator
Home Mercedes, Inc
6355 Sw 2nd Street
Miami, FL 33144

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on May 19, 2016 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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

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