RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Professional Home Care Iii, Inc
447 East 26 Street
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a complaint (CCR #2016002617) inspection survey conducted on , 2016 and concluded on , 2016, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within ten business days of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency Class II

Directed Corrective Actions:

1. The facility must create a policy to address communication with health care providers and family members/ responsible parties following a change of condition. Examples include but not limited to: an injury, significant loss of weight/ decrease in appetite, development of , /non-healing , , development/ worsening of symptoms, with no relief, stomach complaints/concerns going longer than 1 day, with head injuries, activity or any condition which required medical attention or a transfer to an acute care facility. The policy should include that the Administrator be notified immediately of any resident change and documentation be made in the medical record of all notifications and any orders or instructions given to the staff. The Administrator must have an active role in determining level of care options for the resident. All direct care staff must be trained on the new policy. Documentation of the training, content and sign-in sheet, must be maintained in the facility and available for review by the Agency upon request. **This requirement must be met by , 2016.**

2. The facility must immediately refer any resident identified by any direct care staff member to have functional abilities, physical/sensory limitations and /behavioral status inconsistent with their current health assessment or needing additional supplemental services and special precautions not identified in their current health assessment, to their physician/physician extender for an evaluation to determine a resident's current status, care needs and appropriateness to remain in the facility . **This requirement must be met by , 2016.**

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

3. The facility must develop and implement a policy and procedure for the coordination of care between third party providers and the facility. The policy must include who will be responsible for contacting and coordinating the third party providers, indicating how/when providers are notified of medical orders, specify notification instructions when the recommended care/ treatments are unable to be performed as ordered by the health care provider and how the facility will coordinate and provide oversight of the third party provider's care. The policy must address the facility's responsibility to document the coordination and oversight with the third party providers and the administrator's specific role in the coordination of care within the facility. As part of the policy, the heath care provider visit notes must be maintained in the resident record. The facility must implement a written log for all residents receiving care from any third party providers. The log must include, at a minimum, name of resident who is receiving care, the name of the third party provider who is providing the care, and documentation of any care services and treatments completed including the course of the progress of care/ services rendered to the resident. **This requirement must be met by , 2016.**

4. The facility must create a policy regarding overall observation of the resident, by implementing a resident observation log which requires the care staff to indicate any changes identified about each resident daily. The log must include documentation of any care provided by the staff including: wellness checks, turning and repositioning, care, meal intake / fluid intake, , . The policy also must include how staff are to document assistance with activities of daily living, including toileting. All direct care staff must be trained on the new policy. Documentation of the training, including content and sign-in sheet, must be maintained in the facility and available for review by the Agency upon request. **This requirement must be met by , 2016.**

5. The facility must review every resident's health assessment, documented on an AHCA Form 1823, to ensure it is complete and accurately reflects the resident's condition and the examining physician/physician extender's assessment. The facility must apply the resident assessment/records requirements herein for any and all residents admitted to the facility. **This requirement must be met by , 2016.**

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 or Verlande Exil, Health Facility Evaluator Supervisor, Miami, (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve

D7JR

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016002617 was conducted from to at Professional Home Care III, license # 94. The facility had deficiencies found at the time of the visit.

0010 Admissions - Continued Residencv

Based on observation, interview and record review, the facility failed to determine ongoing appropriateness for continued residency for 3 of 3 sample residents (Residents #1, #2, and #3). This was evidenced by the facility's failure to meet the increased care needs, including supervision for residents experiencing a decline in health resulting in the development of significant weight loss, complications, and which required a higher level of care and hospitalization.

The findings include:

1. Review of Resident #1's medical record indicated the resident was admitted to the facility on . Review of the resident ' s health assessment form dated / indicated the resident had diagnoses of , , and a history of . He required assistance with all his activities of daily living (ADLs) and medication management. On admission, Resident #1 ' s weight was recorded at 125 lbs.

Review of Resident #1's progress notes from admission indicated that the resident was ambulatory throughout the facility but was unsteady and had numerous injuries/ with skin lacerations. Review of the note dated indicated that the resident became more disoriented and had lost weight (2015 recorded weight- 120 lbs.). The record indicated that the resident ' s family was concerned about his weight loss and had contacted his physician for an evaluation. No facility documentation was observed in the record regarding the results of the evaluation and interventions made by the facility. Review of the progress note dated / indicated that the resident remained ambulatory and had a good appetite. (2015 recorded weight- 111 lbs.). Further review of the notes indicated no notification of the additional 9 lbs. weight loss to physician.
Further review of the progress notes dated / indicated that Resident #1 was " not doing well " and he was forgetful and unable to use his walker for ambulation. The note reflected that his family was notified of his condition.

Review of the progress note dated / indicated that Resident #1 was experiencing a "bad ' ' with coughing" and the resident ' s physician ordered and for . Further review of the notes dated indicated that Resident #1 was " still not feeling well " and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HOME CARE III, INC	**447 EAST 26 STREET HIALEAH, FL 33013**

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

had a poor appetite. (2016 recorded weight- 105 lbs.). The note indicated that the resident was prescribed another by the physician. There was no documentation that the facility had notified the physician of Resident #1's weight loss of 6 lbs. from to . Review of the progress note dated indicated that Resident #1 was "in bed and not getting up " and his appetite remained poor. Review of the progress note dated indicated that the resident ' s family was notified that the resident was having a " possible reaction," both of his hands were , he wouldn't open his mouth to eat and he had a skin . Further review of the note indicated that the resident continued to refuse to eat any food and had sacral redness due to immobility. The progress note indicated that the resident ' s family made the decision to transfer the resident to the hospital for evaluation.

Review of the hospital records for Resident #1 dated indicated that the resident was assessed in the emergency have an , and decreased responsiveness. Further review of the physician note indicated that the resident had not been eating or taking anything to drink for 3 days and now was unresponsive. The resident was documented as being able to ambulate and having a good appetite until a few days prior to admission and now was experiencing and coughing. The assessment further indicated that Resident #1 was observed to be unable to communicate, and he was contracted into a position, to have hands and feet and had , on his sacrum and both hips. The assessment indicated the diagnoses of , suspect , , , , chronic and decline in function.

In an interview with Resident #1's family member on at 5:15 PM, the resident was described, on his admission to the facility, to have but was very active, ambulating all day, as well as during the night. The family member stated that the facility staff had insisted that Resident #1 had a "good appetite" but his weight loss was a major concern for the family. The family member stated that Resident #1 had lost over 20 lbs. since his admission to the facility. The family member stated that several attempts were made to speak with the facility physician regarding the resident ' s weight loss but no response was received. The family member stated that Resident #1 had always been so active, that when he was observed by the family member to be in bed, and refusing to eat or drink, the resident needed to be transferred to the hospital for evaluation immediately. The family member stated that she didn't understand why the resident was allowed to remain in the facility to decline further and develop .

Review of Resident #1's progress notes dated on indicated the resident was readmitted to the facility on hospice services and was to receive care every 3 days for a sacral , '. Review of the hospice initial assessment dated on / indicated Resident #1 was bedbound, requiring total ADL care and having requiring the resident to be fed a thickened liquid diet, his head to be elevated and precautions maintained. Additionally,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

Resident #1 was assessed to have 3 , a sacral ; left elbow and a right leg . Review of the hospice orders dated on indicated that Resident #1 developed left hip which was treated along with the other wounds. The hospice nurse noted that she instructed the facility staff to turn and reposition the resident every 2 hours and provide proper skin care. Further review of the resident ' s record showed no documentation of any observations of the resident ' s condition or care provided by the facility staff after his readmission.
In an interview with the Administrator on at 12:00 PM she stated that when Resident #1 was admitted to the facility, he was ambulatory, spending all day and most nights, walking throughout the facility. She stated that the resident was unsteady and on several occasions lost his balance, bumping into walls and objects, causing . The Administrator stated that the resident had progressive and was unable to communicate his needs. She stated that Resident #1 required assistance with all of his ADL care and had a good appetite. She stated that she was aware of the resident's significant weight loss but the resident ' s health care was being coordinated by his family member. The Administrator stated that she attributed the resident's weight loss to his declining mental condition. She stated that the facility had a facility physician that visited monthly but she could not provide any documentation for review. She stated that Resident #1 had developed a with and and the physician had prescribed multiple for the resident. The Administrator stated that she was notified that Resident #1 had no improvement with the and was refusing to eat or drink for several days. She stated that Resident #1 also developed a skin / possible reaction to the . The Administrator stated that the resident ' s family member came to the facility and made the decision to transfer Resident #1 to the emergency evaluation. She stated that upon Resident #1's readmission the hospice personnel were involved with his care. She was unable to provide any documentation of the care and services that the facility had provided to the resident based on the hospice recommended plan of care, when the hospice personnel were not at the facility.

2. Review of the medical record for Resident #2 indicated the resident was admitted to the facility on with medical diagnoses including , , multiple s/p head , , and /ex-smoker. Review of the resident health assessment dated on / indicated that the resident required supervision for decreased function and precautions. The resident required supervision for ambulation, eating, and transfers and assistance with bathing, dressing, personal care, toileting and medication management.

Review of Resident #2's progress note dated indicated that the resident's family member had taken the resident to the hospital for evaluation of a fluid filled on his left leg. Further review of the notes indicated that Resident #2 was treated at the hospital and prescribed and received care treatments on and . No further documentation was noted in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HOME CARE III, INC	**447 EAST 26 STREET HIALEAH, FL 33013**

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

the facility record after about the resident ' s .

Review of the facility admission/discharge log indicated that Resident #2 was transferred to the hospital on for "evaluation of leg ."

Review of the hospital records for Resident #2 dated indicated that the resident was admitted after sustaining a generalized tonic-clonic due to sub-therapeutic medication levels. The resident was assessed by the physician to have sunburn and multiple fluid filled/ to both lower extremities (see photo evidence), , injury/ to knees and laceration to his tongue. The physician note indicated that the resident had sustained a and on the concrete from an upright position. The assessment indicated that the resident had resting tremors, and his right arm was contracted. The assessment further indicated that Resident #2's sister came to Assisted Living facility and found the resident to be , with a laceration to his tongue. Further review of the hospital medical record indicated that Resident #2 was admitted for general observation and treatment of on his lower extremities. Review of the hospital care note dated on / / indicated that Resident #2 had lower extremities with bullaes, s/p sun exposure. care was provided with cream 1% to both extremities, twice a day and cultures were obtained.

In an interview with Resident #2's family member on at 12:45 PM she spoke through an Agency translator. The family member stated that she would regularly visit the resident at the facility. She stated that on at approximately 7:00 PM, when she arrived at the facility, she observed Resident #2 sitting in a recliner chair with his feet elevated, with being administered and very . The family member stated that she observed dried inside the resident's mouth, around his and noted that both his lower legs were reddened with numerous small on them. She stated that she overheard other residents talking about the resident, saying that the resident had been found on the floor by the staff. She stated that she "instructed" the facility staff to call 911 to transfer Resident #2 to the hospital for evaluation of activity. She stated that at the hospital, Resident #2 was assessed to have an increase rate and . Additionally, she was informed that the residents ' legs were sun and the leg were a possible reaction between sun exposure and the medications that the resident was prescribed. The family member stated that the resident would not be returning to the facility, but admitted to another facility which would provide supervision for Resident #2. She stated that she did not receive any notification that Resident #2 had activity or sustained a with injury until she arrived to visit him.

3. Review of the medical records for Resident #3 indicated that the resident was admitted to the facility on . Review of his current Health Assessment form dated / / indicated that Resident #3 had medical diagnoses including right sided , s/p accident ( ),

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

dependent , , chronic , and history of . The resident required total care for all his ADL care; he was bedridden, required a pureed diet and was receiving hospice services.

In an observation of Resident #3 on at 10:30 AM, he was observed to be lying flat in a bed, which was low to the ground and had side rails raised. The resident's dimly lighted and had no window. Resident #3 was alert, but did not verbally communicate when addressed. At this time the caregiver present stated that Resident #3 remained in bed due to his history of while attempting to get up from the chair. She stated that the resident required total staff supervision if he was transferred to a chair. She stated that the resident ate all his meals in his bed, and he only had functional use of his left arm which required staff assistance with eating. She stated that the resident no longer left his stayed in bed.

Review of Resident #3's progress notes indicated that he was admitted to hospice services on / for functional decline, and . Review of the initial Hospice notes for Resident #3 on his admission date on / indicated that the resident was alert but nonverbal and disoriented x3. He was severely with right sided , , and tremors. Resident #3 was identified to require total care for all his ADLs. The resident was identified as a risk and care planned for to include supervising the resident 24 hours a day. Further review of the hospice notes indicated that Resident #3 had on and , after he made attempts to stand unassisted when sitting in a recliner chair. Review of the notes indicated on , the resident was found on the floor and had hit his head and elbow which required assessment by the hospice nurse. X-rays were ordered and showed no injury identified. Review of the hospice physician orders dated on indicated that the resident was to be supervised at all times and to maintain precautions.

In an interview with the primary hospice nurse on at 12:00 PM she stated that she visits the resident weekly and that Resident #3 was nonverbal and totally dependent for all his daily care. She stated that the resident had right sided from a and had overall generalized . She stated that the resident had sustained several due to his attempts to stand by himself. She stated that due to his high risk, he must have 100% supervision when he is a chair, to prevent him from attempting to stand or reposition himself. She stated that the hospice team and physician had agreed that the resident required 100% supervision. She stated that there was no reason why Resident#3 could not be transferred to a chair and brought out of his the facility staff would need to provide one on one supervision to prevent .

Review of the hospice health care provider note dated indicated the resident was alert but dependent for all ADL care, was bedbound and combative at times with staff. The note indicated the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

resident was unable to reposition himself in bed and required bed rails for his safety. The resident required the head of the bed to be elevated to prevent and had diminished breath sounds in both lungs. The resident had decreased appetite and required a pureed diet. The note indicated that the resident was but had no .

In a further interview with the hospice nurse on at 12:15 PM she stated that Resident #3 had been observed on to have increased and pain in his chest area, but he had no symptoms of or . She stated that a hospice on- call nurse had visited the resident on at 7:30 PM to evaluate his condition. She stated that the on-call nurse had notified the hospice physician and treatments were ordered every 8 hours for the increased . Review of the hospice plan of care dated indicated the resident ' s head of bed to be elevated to assist with effort, barrier cream applied with incontinence care and to reposition every 2 hours to prevent .

Review of the 2016 Medication Observation Record (MOR) for Resident #3 on at 12:00 PM indicated that the resident had not received the prescribed treatments. Further review of the MOR indicated that the resident had been prescribed and inhalation solutions via three times daily, 8 AM, 2 PM, and 8 PM.

In an interview with the Administrator on at 12:30 PM, she stated that the unlicensed facility caregivers had been administering the routine treatments to Resident #3, since the hospice nurse was not available throughout the day to administer the treatment. The Administrator stated that she was unaware if the medication had been received or administered to the resident as ordered on .

In an additional interview with the Administrator on at 1:30 PM she stated that the resident had developed symptoms and the hospice nurse had been to evaluate the resident. She stated that there was no documentation that the facility staff were following the resident's hospice plan of care to maintain the head to his bed elevated and to reposition him every 2 hours for comfort and prevent . She stated that the resident had a good appetite and the staff were assisting the resident to eat but she was unable to demonstrate the meal intake by the resident.

In an interview with Resident #3's health care proxy on at 10 AM, she stated that she was appointed to be the resident ' s proxy and she is updated about his condition primarily by the hospice provider. She stated that she had been notified that Resident #3 had sustained several and had been consulted about his required care. She stated that Resident #3 was identified as a risk and required supervision by staff. She stated that Resident #3 was confined to his bed to reduce the risk of . She stated that she had been informed in 2016 that the resident's condition was stable and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

she was unaware that the resident had recently developed which required 24 hour nursing care for administration of medications.

In an interview with the hospice team manager on at 5:00 PM, he stated he was aware that Resident #3 was confined to his bed due to his history of . The team manager stated that he also had been notified that the resident's dark, and provided the resident with little interaction with other residents. The team manager stated that he had made requests to the Administrator to move the resident to a brighter , closer to other resident activity but no had been completed. He stated that Resident #3 could be transferred to a chair occasionally, but he would require total 100% supervision by the staff to prevent injury. He stated that changing the resident's position from lying in bed would be good for the resident's overall health. He stated that he had been notified that Resident #3 was experiencing increased symptoms, including and treatments were prescribed. The team manager stated that he was not aware that Resident #3 had not received the breathing treatments starting on as ordered. Furthermore, he stated that he was not aware that unlicensed caregivers were administering the daily routine treatments to the resident. The team manager stated that he was placing Resident #3 on 24-hour hospice nursing care to provide the necessary treatments and monitor the resident's condition.

Class II

0053 Medication - Administration

Based on observation, interview, and record review, the facility failed to ensure that unlicensed staff only provided assistance with self -administration of medications. The facility failed to have a licensed staff member administer medications to 2 out of 3 sampled residents (Residents # 2 and #3) who were prescribed treatments.

The findings include:

1. Review of the medical record for Resident #2's health assessment dated / indicated the resident required overall supervision for decreased function and supervision for ambulation, eating, and transfers. He required assistance with bathing, dressing, personal care, toileting and self-administration of medications.
Review of the 2016 Medication Administration Record indicated that Resident #2 was prescribed and had been administered solution 0.083% treatment twice a day, at 8 AM and 8 PM by the unlicensed facility staff.
In an interview with the Administrator on at 12:30 PM, she stated that Resident #2 was unable

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	06/15/2016
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

to administer the treatment himself therefore the unlicensed facility staff had been administering the treatments to him since the facility did not have nurse on staff. She stated that she was aware that unlicensed staff are not permitted to administer treatments.

2. Review of the medical records for Resident #3's Health Assessment form dated / / the resident required total care for all his activities of daily living (ADL), he was bedridden, and was receiving hospice services. The form further indicated that the resident required assistance with self-administration of medications.

Review of the 2016 Medication Observation Record (MOR) for Resident #3 indicated that the resident had been prescribed and inhalation solutions via , three times daily at 8 AM, 2 PM, and 8 PM. Further review of the 2016 MOR indicated that the unlicensed staff were administering the treatments to the resident.
In an interview with the Administrator on at 12:30 PM, she stated that Resident #3 was not capable of assisting with his treatments therefore the unlicensed facility caregivers had been administering the treatments to him. She stated that the hospice nurse was not available throughout the day to provide the treatments to the resident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Professional Home Care Iii, Inc
447 East 26 Street
Hialeah, FL 33013
RE: CCR #2016002617

Dear Administrator:

This letter reports the findings of a state licensure survey that was concluded on , 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. **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 will include an 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

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