STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968292	06/23/2016
NAME OF PROVIDER OR SUPPLIER **EL RENACER DE ANA INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5900 NW 7 STREET** **MIAMI, FL 33126**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on . El Renacer de Ana Inc. with a Limited Mental Health component, license # 12236, had the following deficiencies found at the time of the survey:

0077 Staffing Standards - Administrators

Based on record review and interview facility failed to appoint a Manager for the facility who did not administer another one.

Findings included:

On at 11:00 AM during record review was revealed that the Facility had not appointed a Manager for this facility.

On at 12:45 PM the Administrator was informed that he was required to have a manager for this facility because he was the administrator at two facilities and he needed to have a Manager in each one. He stated that he was going to take care of it as soon as possible.

Class III

0162 Records - Resident

Based on record review and interview, the facility failed to ensure one out of six sampled residents (#6) to have a Power of Attorney (POA), Surrogate or Guardianship documentation in their charts.

Findings included:

On at 10:01 AM, record review found resident #6 her granddaughter signed her documents without a POA/Surrogate or Guardianship notarized properly. No Power of attorney was found on the resident's record.

On at 1:00 PM during an interview with administrator, he stated, he was going to contact the granddaughter and request a POA as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
El Renacer De Ana Inc
5900 Nw 7 Street
Miami, FL 33126

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted 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. 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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