

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/19/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966689	(X3) DATE SURVEY COMPLETED 07/01/2016
NAME OF PROVIDER OR SUPPLIER REBULL FAMILY CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9760 MEMORIAL ROAD MIAMI, FL 33152	

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

0000 Initial Comments

A Change of Ownership survey was conducted on 7/1/16. Rebull Family Care Inc with Limited Mental Health component, license number 10852, had a deficiency found at the time of the survey.

0125 Fiscal - Surety Bonds

Based on record review and interview, the facility failed to have a surety bond with the minimum bond proceeds that equal twice the value of the residents' monthly aggregate income for one out of six (Resident #1).

Findings included:

Resident #1 record review showed that no family members were listed in the demographic form.

Attempted to interview Resident #1 was conducted on 7/1/16 at 10:10 AM. She was not available.

Interview conducted on 7/1/16 at 11:10 AM, the Administrator stated that she is the representative payee of Resident #1 who receives social security checks directly to the business account. She stated "I do not have a surety bond."

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Rebulf Family Care Inc
9760 Memorial Road
Miami, FL 33152

Dear Administrator:

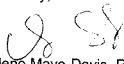
This letter reports the findings of a Change of Ownership licensure survey that was conducted on , 2016 by representative(s) of this office.

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 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



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