

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/17/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967491	(X3) DATE SURVEY COMPLETED 08/03/2016
NAME OF PROVIDER OR SUPPLIER SUAREZ RESIDENT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 13371 SW 50 STREET MIAMI, FL 33175	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on 08/03/16. Suarez Resident Inc.(license # 11531) had the following deficiency 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 (#4) sampled residents.

Findings included:

Interview on 08/03/16 at 12:50 PM, the facility's stated that she was a representative payee of one Resident #4 who received social security checks. She stated "I do not have a surety bond."

Record review on 08/03/16 showed that Resident #4 (admitted on 07/15/16) social security check was deposited into the facility's bank account. The check was mailed on 08/02/16 under facility and Resident #4's names.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Suarez Resident Inc
13371 Sw 50 Street
Miami, FL 33175

Dear Administrator:

This letter reports the findings of a Standard Biennial 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

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