STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965173	08/15/2016
NAME OF PROVIDER OR SUPPLIER **XIOMARA HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **4321 SW 1 STREET** **MIAMI, FL 33134**	

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

0000 Initial Comments

An Extended Congregate Care (ECC) Monitoring survey was conducted on / . Xiomara Home with ECC, license #9598, had a deficiency at the time of survey.

0010 Admissions - Continued Residency

Based on observation, record review, and interview the facility failed to have an updated face to face medical examination completed by a health care provider as part of the continuing residency criteria for a resident after a significant change for 1 out of 5 sampled residents (Resident # 1).

Findings included:

During tour of the facility on / at 1:15 PM observed Resident #1 lying in her bed in #1.

Record review of Resident #1's record revealed that she is receiving hospice services since with a diagnosis of . The last health assessment completed on / / and reflected that resident requires assistance with her activities of daily living and that she is receiving hospice services.
On / at 1:31 PM Staff A stated that at the time of the survey the resident was able to assist with feeding but required total assistance with the rest of her activities of daily living.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Xiomara Home
4321 Sw 1 Street
Miami, FL 33134

Dear Administrator:

This letter reports the findings of an Extended Congregate Care 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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