RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

[redacted], 2016

Administrator
Buena Vista Health Care Ii, Corp
7968 W 14 Court
Hialeah, FL 33014

Dear Administrator:

This letter reports the findings of a Change of Ownership state licensure survey that was conducted on [redacted], 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 [redacted], 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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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966265	09/21/2016
NAME OF PROVIDER OR SUPPLIER **BUENA VISTA HEALTH CARE II, CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **7968 W 14 COURT HIALEAH, FL 33014**	

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

0000 Initial Comments

A Change of Ownership (CHOW) Survey was conducted on / . Buena Vista Health Care II (license # 10490) had the following deficiencies identified at time of the survey:

0078 Staffing Standards - Staff

Based on record review and interview the facility failed to have documentation of freedom from communicable for one out of four (C) facility Staff.
Findings included:
Record review on / showed the facility had a blank documentation of freedom from communicable form for Staff C (caregiver).
During an interview on / at 3:15 PM, the Administrator stated that he would fax documentation to the office and that he would make corrections. Documentation was not received.
Class III

0079 Staffing Standards - Levels

Based on observation, record review and interview the facility failed to have an accurate written work schedule that reflects its 24-hour staffing pattern for a given time period.
Findings included:
On / at 10:30 AM, observed Staff B by herself with six residents. Staff B stated "I cover facility staffs' days off, but during those days that I ' m scheduled to work here, I ' m by myself."
A review facility staffing pattern posted on board revealed the following schedule for / :
Staff C scheduled from 7:00 AM to 7:00 PM
Staff B scheduled (OFF)
Staff D scheduled (OFF)
Staff A scheduled from 7:00 PM to 11:00 AM
Staff A scheduled on Call 24 hours
On / at 11:15 AM, the Administrator arrived at the facility.
During an interview on / at the exit conference, the Administrator acknowledged stated that he will make corrections. He acknowledged that facility scheduled was not reflecting the corrected staffing. He stated "I ' m here at the facility on calls as needed and Staff C is at the hospital."

Class III

Z814 Background Screening Clearinghouse

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

Based on observation, record review and interview, the facility failed to register the employees on the AHCA Background Screening Clearinghouse roster.
Findings Included:
Observation on / at 10:30 AM up-on arrival to the facility was Staff B (caregiver) by herself with six residents providing personal services to them.
Review facility staffing pattern posted on board revealed the following
Staff C scheduled from 7:00 AM to 7:00 PM
Staff B scheduled (OFF)
Staff D scheduled (OFF)
Staff A scheduled from 7:00 PM to 11:00 AM
Staff A scheduled on Call 24 hours
AHCA Background Screening Clearinghouse database showed on / that Staff B, C and D were not registered on the agency clearinghouse. The Administrator was the only person registered on the clearinghouse.
During an interview on / at 3:15 PM, the Administrator stated "I will made corrections. I will register facility staff with the agency clearinghouse."
Unclassified