

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 10/31/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967322	(X3) DATE SURVEY COMPLETED R 10/18/2016
NAME OF PROVIDER OR SUPPLIER CARING HANDS ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12735 NORTH MIAMI AVENUE MIAMI, FL 33168	

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

0000 Initial Comments

A Standard Biennial 2nd Revisit Survey was conducted on 10/18/2016. Caring Hands Assisted Living (License # 11406) had no deficiencies identified at the time of the survey.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967322	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/18/2016
NAME OF FACILITY CARING HANDS ASSISTED LIVING, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 12735 NORTH MIAMI AVENUE MIAMI, FL 33168

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0010	Correction	ID Prefix AZ813	Correction	ID Prefix	Correction
Reg. # 429.26(1&8) FS, 58A-5.0181(4) FAC	Completed	Reg. # 59A-35.090(3)(c) FAC	Completed	Reg. #	Completed
LSC	10/18/2016	LSC	10/18/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/23/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

October 31, 2016

Administrator
Caring Hearts Assisted Living Inc
8601 Sw 36 Street
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on October 20, 2016 by representative(s) of this office.

Attached is the provider's copy of the State Form, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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

DT9D

