STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966915	**10/26/2016**
NAME OF PROVIDER OR SUPPLIER **DIAZ HOME CARE ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13481 SW 268 TERRACE** **HOMESTEAD, FL 33032**	

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

0000 Initial Comments

A Change of Ownership (CHOW) Survey was conducted on 10/26/16. Diaz Home Care ALF, Inc with a Limited Mental Health license # 11119 had the following deficiency identified at the time of the survey:

0125 Fiscal - Suretv 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 two out of five sampled residents (#3 and #5).
Findings included:
On at 10:31 AM According to the Administrator, he does not have enough money to have a surety bond because he was just starting the business but he was going to make the arrangements to get one.
On at 10:31 AM the Administratorstated that he knew that he had to have a surety bond but he did not have the money or the time to get it, but he was going to take care of it as soon as possible.
Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Diaz Home Care Alf, Inc
13481 Sw 268 Terrace
Homestead, FL 33032

Dear Administrator:

This letter reports the findings of a Change of Ownership state 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 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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