STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953555	**11/14/2016**
NAME OF PROVIDER OR SUPPLIER **SOUTH FLORIDA HOME SERVICES IN**	STREET ADDRESS, CITY, STATE, ZIP CODE **140 NW 9 AVENUE** **MIAMI, FL 33128**	

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

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on 14, 2016. South Florida Home Services Inc (AL 9352) with Limited Nursing Services and Limited Mental Health components had a deficiency identified at the time of the survey.

N277 LNS - Resident Care Standards

Based on record review and interview the facility failed to maintain a copy of the current license of the Registered Nurse contracted by the facility to provide limited nursing services.

Findings included:

Review of the personnel file of the Registered Nurse contracted by the facility to provide limited nursing services revealed that her license expired on /.

On / at 11:10 am spoke to the Registered Nurse contracted by the facility to provide limited nursing services on the phone and she verified that she still is contracted by the facility and that she will send a copy of her license to the facility.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
South Florida Home Services In
140 Nw 9 Avenue
Miami, FL 33128

Dear Administrator:

This letter reports the findings of a Limited Nursing Services 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 , 2017.** 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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