



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

-----, 2016

Administrator
Reyes Home Care #2
1640 Sw 83 Court
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a **second** Licensure Monitoring Revisit Survey concluded on 19, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than -----, 2017.**

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

YOSF



**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/30/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967113	(X3) DATE SURVEY COMPLETED R 12/19/2016
NAME OF PROVIDER OR SUPPLIER REYES HOME CARE #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 SW 83 COURT MIAMI, FL 33155	

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

0000 - Initial Comments

A Licensure Monitoring 2nd Revisit Survey was conducted on 12/14/16. Reyes Home Care #2, license # 11271, had the following deficiency found at time of the survey:

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observations and record review, the facility failed to have an admission and discharge log.

Findings included:

Facility tour on / / at 11:45 AM found that the facility had a census of seven residents.

Record review on / / revealed that the facility's admission and discharge log did not have Resident #2.

Class III

Z827 - Unlicensed Activity - 408.812, FS

Based on observations and interview, the facility exceeded its licensed capacity by providing assisted living services to a total of seven residents while being licensed for six beds.

Findings included:

Facility tour on / / at 11:45 AM found that the facility had a census of seven residents.

Interview conducted on / / at 12:30 PM, the facility's administrator confirmed that the facility had a census of seven residents. She stated "Resident #1 will be discharged. I going to give a 45 day's notice to her."

Unclassified deficiency

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967113	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
Y1	Y2	Y3
NAME OF FACILITY REYES HOME CARE #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 SW 83 COURT MIAMI, FL 33155	

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 AZ814	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 435.12(2)(b-d), FS	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	
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 12/3/16	SIGNATURE OF SURVEYOR 	DATE
REVIEWED BY CMS RO	☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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