STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966844	**04/20/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
SILVER PALM ALF II LLC	**10241 SW 134 AVENUE CROSSINGS, FL 33186**	

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

0000 - Initial Comments

A Change of Ownership Survey was conducted on . Silver Palm ALF II Inc with a standard license and limited mental health component had the following deficiencies at the time of survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed have completed health assessment which documented the type of diet for 1 out of 6 (#1) sampled residents.

Findings as follow:

Record review showed the health assessment for Resident #1 (dated) did not specify the type of diet the resident needed (it was blank).

On at 2:40 p.m. the facility's Administrator acknowledged the findings the health assessment was not completed for Resident #1.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to appoint a health care surrogate, health care proxy, guardian, or a power of attorney for 2 out of 6 (#1 and #3) sampled residents.

Findings as follow:

Contract reviews between the facility and Residents #1 and #3 found they were both signed by a family members of each resident. Record review documented the facility did not have documentation of a power of attorney, health care surrogate, or guardian, appointed for Residents #1 and #3.

On at 2:40 p.m. the facility's Administrator acknowledge the findings that the facility did not have the required paperwork.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Silver Palm Alf Ii Llc
10241 Sw 134 Avenue
Crossings, FL 33186

Dear Administrator:

This letter reports the findings of a Change of Ownership licensure survey that was conducted on , 2015 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.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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
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