

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11967313

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
6/2/2015

Name of Facility

SERENE LIVING FACILITIES

Street Address, City, State, Zip Code

8615 SW 43RD TERRACE
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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0078	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # 58A-5.019(2) FAC		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By
State Agency

Reviewed By

Date:

Signature of Surveyor:

Date:

Reviewed By

Reviewed By

Date:

Signature of Surveyor:

Date:

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 06/23/2015
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967313	(X3) DATE SURVEY COMPLETED R 06/02/2015
NAME OF PROVIDER OR SUPPLIER SERENE LIVING FACILITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 8615 SW 43RD TERRACE MIAMI, FL 33155	

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

0000 - Initial Comments

A Limited Nursing Services Monitoring Survey Revisit was conducted on 06/02/2015. Serene Living Facilities had the following deficiency at time of the survey:

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review, and interview the facility failed failed to limit _____ to half bed rails for 2 out of 6 (Residents #1 and #2) sampled residents.

Findings as follow:

On _____ at 2:30 p.m. observed Resident #1 in bed awake with two half rails attached to one side of the bed (forming a full bed rail) in upright position. Also observed Resident #2 in bed with 2 half rails attached to one side of the bed (forming a full bed rail) in upright position.

Record review showed the facility had a half bed rail order for Resident #2 (dated _____).

On _____ at 3:20 p.m. the facility's Administrator acknowledged the facility full bed rails on Residents #1 and #2's beds.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 15, 2015

Administrator
Serene Living Facilities
8615 Sw 43rd Terrace
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring revisit survey conducted on January 15, 2015 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than January 15, 2015.

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

