STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967900	09/16/2015
NAME OF PROVIDER OR SUPPLIER **MGR HOME #2 INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13620 S W 119 STREET** **MIAMI, FL 33186**	

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

0000 Initial Comments

A Change of Ownership licensure survey was conducted on . MGR Home #2 had deficiencies found at the time of the survey.

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, the facility failed to honor two out of six (#1 and #6)sampled residents' need for privacy and be treated with consideration.

Findings include:

Observation on at 9:00 AM showed that Resident #1 (female resident) and Resident #6 (male resident) share a .

On at 10:17 AM Resident #1 stated "I sleep in the a man. The owner told me that he would be my when she visited me at the hospital."

On at 12:15 PM interview was attempted with Resident #6 but he appeared to be a bit .

Interview conducted on at 2:15 PM, the Administrator stated that Resident #1 and #6 are not a couple. She stated that she is unaware that a male and a female resident cannot share a .

Class III

0181 Emergency Plan Approval

Based on record review and interview, the facility failed to submit an emergency management plan to the local county emergency management agency for review and approval.

Findings include:

The facility record review found the facility did not an emergency plan approval letter from the local county agency.

Interview conducted on at 2:15 PM, the Administrator confirmed that the facility did not have the emergency management plan approval letter available for review.

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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Mgr Home #2 Inc
13620 S W 119 Street
Miami, 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. **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 , 2015.** 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 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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