STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910416	R
NAME OF PROVIDER OR SUPPLIER **SWANKRIDGE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **122 NW 7 STREET** **HOMESTEAD, FL 33030**	

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

0000 Initial Comments

An Abbreviated Biennial Revisit Survey was conducted on 09/30/15. Swankridge, Inc. with a standard license had the following deficiencies found at the time of the survey.

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on observation, record review, and interview, the facility failed to ensure five out of five (Staff A, B, C, D, and E) sampled staff to have the initial 4 hour and/or annual 2 hour training for assistance with self-administration of medication.

Findings included:

On at 11:00 AM record review revealed that Staff A, Staff B, and Staff C did not have the 2 hours training for the assistance with self-administration of medication. Staff A and B's last training was dated / ; Staff C's last training was dated .

On at 11:00 AM record review revealed that Staff D (Hired on / /) and Staff E(Hired on) did not have the initial 4 hour training for assistance with self-administration of medication. Staff was taking care of the resident at the time of the survey.

On at 12:30 PM the owner stated that she knew that she had to correct the deficiencies but she thought that she had enough time to correct them but she was wrong.

Uncorrected Class III

0160 Records - Facilitv

Based on record review and interview the facility failed to have an emergency management plan approved by the count and an annual health inspection.

Findings included:

On at 10:30 AM record review found the facility did not have an approved emergency management plan; the facility's last health inspection was dated .

On at 12:30 PM the owner stated she thought that the revisit inspection was going to be a little later. She showed some documents that show that she is working on getting the health inspection

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

completed.

Uncorrected Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11910416	A. Building B. Wing	9/30/2015

Name of Facility	Street Address, City, State, Zip Code
SWANKRIDGE, INC	122 NW 7 STREET HOMESTEAD, FL 33030

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** Reg. # **58A-5.019(2) FAC** LSC	Correction Completed	ID Prefix **A0081** Reg. # **58A-5.0191(2) FAC** LSC	Correction Completed	ID Prefix **A0082** Reg. # **58A-5.0191(3) FAC** LSC	Correction Completed
ID Prefix **A0083** Reg. # **58A-5.0191(4) FAC** LSC	Correction Completed	ID Prefix **A0085** Reg. # **58A-5.0191(6) FAC** LSC	Correction Completed	ID Prefix **A0086** Reg. # **58A-5.0191(9) FAC** LSC	Correction Completed
ID Prefix **AZ815** Reg. # **408.809, 435.02(2), 435.06** LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:** 10/14/15	**Signature of Surveyor:**		**Date:**
Reviewed By CMS RO	**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**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Swankridge, Inc
122 Nw 7 Street
Homestead, FL 33030

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2015by 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

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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com