STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965854	R / /
NAME OF PROVIDER OR SUPPLIER **SUANY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **20411 SW 116 ROAD** **MIAMI, FL 33189**	

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

0000 Initial Comments

A Complaint (CCR #2015007008 and 2015007976) Survey Revisit was conducted on 11/06/2015. Suany's Home had the following deficiencies at the time of the survey:

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint a separate Manager for each location, the Administrator supervised three assisted living facilities.

Findings as follow:

Record review found the facility's Administrator supervised three assisted living facilities. The facility failed to appoint a separate Manager for each location.

On / / at 10:30 a.m. the facility's Administrator acknowledged the facility did not have a Manager appointed.

Uncorrected Class III

0162 Records - Resident

Based on observation, record review, and interview the facility failed to have complete resident records for 1 out of 7 (Resident #7) facility residents.

Findings as follow:

On / / at 9:20 a.m. observed Resident #7 in facility.

Record review showed the facility failed to have a complete record for Resident #7 including a demographic sheet, orders for medications and services, and a copy of the resident's contract

On / / at 09:20 a.m. the facility's Administrator stated there were no records in facility for Resident #7 because the resident was not sure if he would stay, adding Resident #7 was admitted three days ago.

Uncorrected Class III

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SUANY'S HOME	20411 SW 116 ROAD MIAMI, FL 33189

SUMMARY STATEMENT OF DEFICIENCIES
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Z827 Unlicensed Activitv

Based on observation, record review, and interview the facility failed to obtain a licensure capacity increase prior to providing personal care to a census of seven (7) residents. The facility provided services to residents outside the current license capacity of six.

Findings as follow:

On / at 9:10 a.m. facility tour with Staff B found there were 7 residents in facility.

Residents #3 and #4
Resident #6 and #7
Resident #2 and #5
Resident #1

Staff B stated during the tour the facility had 7 residents that slept there.

On / at 9:20 a.m. the facility's Administrator stated the facility had 7 residents, adding resident #7 was admitted three days ago, but they were not sure if he will stay.
Record review found the facility had 7 residents in the admission and discharge log.

Unclassified

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11965854

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
11/6/2015

Name of Facility
SUANY'S HOME

Street Address, City, State, Zip Code
20411 SW 116 ROAD
MIAMI, FL 33189

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 **A0083** Reg. # **58A-5.0191(4) FAC** LSC	Correction Completed	ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC	Correction Completed
ID Prefix **A0160** Reg. # **58A-5.024(1) FAC** LSC	Correction Completed	ID Prefix **AL243** Reg. # **429.075(1) FS; 58A-5.0191(** 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
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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:** 11/9/15 — **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
Suany's Home
20411 Sw 116 Road
Miami, FL 33189

Dear Administrator:

This letter reports the findings of a complaint 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

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Miami, FL 33166
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