STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967151	**11/03/2015**
NAME OF PROVIDER OR SUPPLIER **GOLDEN TOUCH HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **41 NW 190 STREET** **MIAMI, FL 33169**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2015. Golden Touch Home with Limited Mental Health component had the following deficiency identified at time of survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint in writing a separate manager for each facility, the facility's Administrator supervises more than one facility.

Findings included:

Record review on / / of staff files revealed the facility did not have a manager's record. An Internet search of the Florida heath finder website showed the Administrator supervised two assisted living facilities. It was later found that the manager assigned to the facility is the Administrator at another ALF.

Interviewed with the Administrator on - at 2:15 PM, stated that she was the Administrator for both facilities and has a Manager, but only works at that facility on an on call basis. The on call Manager was contacted on - at 2:20 PM and she stated that her position at the facility was only for an on call basis and she just helps out on occasion whenever she is needed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Golden Touch Home
41 Nw 190 Street
Miami, FL 33169

Dear Administrator:

This letter reports the findings of a Standard Biennial Survey that was conducted on 3, 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 Kristal Branton, Health Facility Evaluator Supervisor at 305-593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

jcj
Enclosure
XG90

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