STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953671	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM GRAND COURT LAKES, LLC	**280 SIERRA DRIVE NORTH MIAMI BEACH, FL 33179**

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

0000 Initial Comments

A Complaint Survey (CCR#2015011376) was conducted from / to / . AM Grand Court Lakes, LLC had the following deficiencies found at time of survey:

0010 Admissions - Continued Residencv

Based on observation, interview, and record review the facility failed have updated health assessments after significant changes in activities of daily living and for 1 out of 7 (#4) sampled residents .
Findings included:
On / at 9:15 AM during facility tour observed Resident #4 ' in # 102 seated in a recliner sofa with foot on her right leg.
During resident record review on / showed that Resident #4 ' (admitted on /) did have a health assessment dated / / diagnoses: D deficiency, High , Lumbar Myelopathy, polymyalgia , , pigmentosa reticularis , Legally , physical or sensory limitation ambulate with walker and nursing medication management. Activities of daily living (ADLs) independent with (ambulation, dressing, eating, self-care, toileting, transferring) and need assistance with bathing. Special diet instruction: regular/no added salt. Need assistance with self-administration of medications. Hospital Bed with half side rails for safety".
Furthermore Resident #4 went to Emergency / Diagnosis was: " Multiple closed of bone, right, initial encounter " . Problem list: T11 , Myopathy, . On / Resident #4 ' was admitted on medical center on / and were discharge on / " discharge diagnoses: " (see photo).
On Resident #4 ' was admitted on at 6:46 PM at the hospital with diagnoses Head Injury _PGH- "should follow up with physician in 1 day. On at 13:48:13 Fire Rescue dispatched and arrived at destination on at 14:31 HX present cause: / Slipped/ Tripped. Complaint: head pain. On Resident #4 ' was transfer to the Hospital diagnoses: head injury, female you should follow up with the following physician in 2 days.
During an interview on / at 9:20 AM Resident#4 stated I ' m living here for 3 years. She stated I did I here few times "maybe five times". She stated that she on the . She stated I want the facility repair my . She stated I ' m scare about the bathtubs I take showed on the toilet with clothes (towels). She stated certified nursing assistant (CNA) showed me how to do it. She stated I have now in my rights food. She stated I was very independent person and now I need to learn how to slow down. She stated my husband two times here.
During an interview on / at 3:15 PM, Administrator stated that Resident #4 ' did have history of . She stated this was staged when changes were occurred at facility (administration and construction) facility administrator acknowledged that Resident #4 did not have new health assessment with significant changes on record for review.

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Class III

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to provide adequate supervision to meet the needs of two out of six (#4 and #6) sampled residents. Facility failed to assess one out six residents to have a history of falling in the facility. The facility failed to develop a plan of intervention to prevent imminent risk for serious injury or harm to two of six (#4 and 6) residents sampled.

Findings included:

1. On /. at 9:15 AM, during the facility tour Resident #4 was observed in # , 102 seated in a recliner sofa with a foot on her right leg.

During resident record review on / it was revealed Resident #4 was admitted on / . The resident had a health assessment dated / with diagnoses to include: D deficiency, High , Lumbar Myelopathy, polymyalgia , pigmentosa reticularis, Legally , physical or sensory limitation ambulate with walker and nursing medication management. Activities of daily living (ADL's) independent with ambulation, dressing, eating, self-care, toileting, transferring and need assistance with bathing. Special diet instructions: regular/no added salt. Need assistance with self-administration of medications. Hospital Bed with half side rails for safety."

Furthermore, Resident #4 went to the Emergency / and the diagnosis was: "Multiple closed of bone, right, initial encounter." The Problem list included: T 11 , Myopathy, . On / , Resident #4 was admitted to the medical center on / and was discharged on . Discharge diagnoses:

Record review revealed on at 1:48PM, Fire Rescue was dispatched and arrived at the facility on at 2:31PM. The documentation revealed, HX (history) present cause: / Slipped/ Tripped. Complaint: head pain. On , Resident #4 was admitted at 6:46 PM to a local hospital with diagnoses of Head Injury , "should follow up with physician in 1 day. On / Resident #4, was transferred to the hospital with diagnoses to include: head injury, , and follow up with the following physician in 2 days.

During an interview on / at 9:20 AM, Resident#4 stated, I'm living here for 3 years. She stated, I did here a few times "maybe five times." She stated, she in the . She stated, I want the facility to repair my . She stated, I'm scared of the bathtubs. I take shower on the toilet with clothes/towels. She stated, the certified nursing assistant (CNA) showed me how to do it. She stated, I

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now have a in my right foot. She stated, I was a very independent person and now I need to learn how to slow down. She stated, my husband two times here.

During an interview on / at 3:15 PM, the Administrator stated, Resident #4 has a history of . She stated, this was happened when changes occurred at facility with administration and construction.

Record review on / revealed, a facility agreement documenting a Risk Acknowledgement that states, "I, the undersigned, understand that the Resident is considered " at risk" for based on a health assessment and prior medical history. I also understand that a may have severe consequences and result in injuries including lacerations, broken bones and even .
I acknowledge, assisted living facilities are specially designed to offer residents freedom, independence and autonomy, and that 24-hour one-on-one care is not provided. I further understand and acknowledge that AM Grand Court Lakes, LLC cannot make any assurance that a resident will not . I have been given the opportunity to have questions answered and discuss this risk with AM Grand Court Lakes, LLC employee's.
Record review on / revealed, Resident #4's chart has a document titled, discharge summary and dated . The form reflected, Resident #4 was admitted on and discharged on , and documents, Resident #4 requires Level Once in which include standard services as well as supervision with bathing and dressing and scheduled transportation to MD office.

2. Record review revealed Resident #6's personal file documented a hospitalization on / and had the following information:
Discharge diagnosis:
" (Patient) was brought to ER (emergency) from the ALF (Assisted Living Facility), was noted by the ALF Staff to have facial . was admitted and evaluated, she had a lump on the left side of forehead, C/Scan (Computed Tomography Scan) of the face showed that had hematoma of the left side of head and had AC. of the Roof of the Right Orbit. Patient has and she is not able to give any information. "
The Form 1823 dated on / documented, on page #1, Resident #6 medical diagnosis reflected no known , , and Chronic Kidney . Resident has memory problems, , disoriented, unable to administer her own medications + needs help with her daily living activities. Resident has , sometimes gets , unable to live independently and has . Resident needs administration of medications including , checking her sugar, 3x daily, preparation of diet, assistance with daily living activities. Patient has and has been used to getting out of her house.
Form 1823 on page #2 reflects that Resident needs assistance for bathing, dressing and .
Resident needs supervision on ambulation and toileting. Resident needs total assistance for transferring. Resident is independent eater. Resident special diet instruction reflects diet, no added salt, low

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fat/low [illegible], low [illegible] and low [illegible] diet. Resident has a diagnosis of communicable [illegible] has Chronic [illegible], and it stated that Resident required 24-hour nursing or [illegible] care. The resident had [illegible]. However, the 1823 Form documented the Resident needs can be met in the facility. In comparison, the Form 1823 signed on [illegible] reflected, " Resident's needs cannot be met by facility due to Patient should be in a facility where there is nursing care and supervision. [illegible] needs [illegible] to be administrated + [illegible] sugar has to be check regularly.

The Progress notes dated on [illegible] documents, "Resident observed by Home Health Nurse and facility staff at dining table (while getting ready for lunch) with head down on the table very [illegible] observed to both eyes. Doctor immediately called orders received transfer to emergency [illegible] evaluation. Son notified. .... resident transported to ER. On [illegible]/[illegible], a Meeting with [] is sister and Exec Dir []. [] stated, "Mom has a fx in her face. Someone is going to pay." " Exec Dir handled meeting will have investigation done. On [illegible]/[illegible], received call from social worker of Hospital states," Resident #6 is being discharged today back to CCL. "This write advise her to speak with family as they stated, " We are not happy with the services CCL is providing."

For activities of daily living Resident needs supervision for ambulation and toileting. Resident needs assistance for dressing, eating and self-care ([illegible]). Resident needs total assistance for transferring, and she is independent for eating.
Resident special diet instructions reflect [illegible] diet, no added salt, low fat/low [illegible], low [illegible] and low [illegible] diet.
Record review revealed Resident #6 had order signed dated on [illegible] that stated, " Place mattress on the floor for safety purpose." The Resident had an order for the use of half bed rails signed on [illegible]/[illegible] with a diagnosis of Gait Difficulty, [illegible] of legs, [illegible] and [illegible]. Also, the resident had an evaluation on [illegible]/[illegible] which stated, " [illegible] D 50,000 IU Q week, D/C [illegible], [illegible] Precautions, encourage PO (by mouth) fluids and [illegible] 525 mg.
Interview on [illegible]/[illegible] at 9:39 am revealed the Administrator stated, " Resident #6 was not on [illegible] precautions when she arrived to the facility. She was able to walk and move around, however, she became sick, her stomach was distended, she had [illegible], and she started to decline. Therefore, we had to provide a higher level of care for her because she was not as she used to be, and she could not live in the ALF area anymore. She was moved to the memory care unit. However, she was transferred to the Memory Unit because she was an elopement risks resident. The administrator reported, Resident #6 was transferred to the Memory Care Unit because there are less Residents and more CNA's. During the daytime, the Memory Care unit has two CNAs, and at night time there are three CNA's. The doctor recommended hospice for Resident #6, but the family declined."

Further interview on [illegible]/[illegible] at 9:55 am revealed, the Administrator stated, " Resident #6 slept in the assisting living facility [illegible] 501, but she was transferred to the Memory care unit because the night

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shift staff reported the resident was saying, "I am going home, I am not staying here." Therefore, Resident #6 was transferred to A 505 the next day on / . The administrator reported, the family did not like the change because they could not understand that she was an elopement risk, and I did not want to have an incident of elopement in the facility.

Interview on / at 9:58 am revealed, the Administrator was asked regarding discrepancy between interview at 9:39 am and 9:55 am, and she stated, " I have so many things in my head, and I cannot remember exactly everything. "
Interview on / at 10:00 am revealed, the Administrator stated, if a resident . The Resident calls to the front desk, and the CNA will go to assist the Resident. If there is , we call for emergency, but if the Resident states that he/she is okay, we will call the primary doctor for assessment and X-ray. The Administrator stated, " To be honest, I cannot record if Resident #6 here or at her family's house, because she kept coming back and forth. A CNA reported, that she had her face down on the table, and we sent her to the hospital.

Interview on / at 11:59 am revealed, Staff B states, " I do not remember exactly that day, but I will use my notes. On for safety precaution the Doctor wrote an order for the use of the mattress on the floor, but there was a verbal order on / per the Doctor." Staff B stated, " Resident #6 left with the son on / and came back to the facility on with both daughters, her sugar was 437, which was high, and we gave the , and they took her back with them. On , Resident #6 was still out, and the family states that she will be out for two more days, and we provided medications for two days. On / , she came back to CCL, she was assessed and she was okay. On , she was okay in her , and 9/9/6 she was okay. On / , she was seen by the Doctor. On , we were making rounds, and she was non-verbal and , we sent her to ER, and notified the doctor.

Interview on / at 12:20 pm revealed, Staff H (CNA) stated, " I have been working in this facility since of this year. I am happy to work here especially at the Memory Care Unit. They are like family and I know all of them well. I work from 7:00 am - 3:00 pm, I do not know the specific days because administration rotates my days, and I am full time.
Staff H stated, "The Memory Care Unit floor is on the fifth floor, and it is a closed unit. This unit is for Residents that have and/or are elopement risk. I used to assist Resident #6 when she was living in the Memory unit in . When she arrived to the facility she used to walk, and she just needs assistance. One day, I saw her stomach distended, and she did not want to eat. Therefore, I reported this to the office, and she went to the hospital. However, when she came back from the hospital, she was down. She went two or three times to the hospital until she had an operation, but she came back worse. One day, I found her sleeping with the mattress on the floor for precautions because she moved a lot."

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Staff H stated, " Resident #6 stop walking, became and needed to be fed. I was feeding her the day her face down to the table, she did not want to eat, I stood up and went to feed another Resident, and I heard when her face down on the table. I approached Resident #6, and she was unresponsive. I did not notice any bump or redness in her face. I called administration mostly because she was unresponsive. The nurses came, and she went to the hospital on that day. I was working by myself and there were between 8-10 residents, but most of them feed themselves, it is an easy unit. Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and interview, the facility failed to maintain a written physician's order for the use of a full bed rail for 1 out of 7 (#4) sampled residents.

Findings included:

During the facility tour on / at 9:15 AM resident #4 was observed in B. The resident had half bed rails attached to her bed.
Record review on / showed Resident #4 admitted on did not have any written physician's order from the use of bed rails or a signed consent to the use of half bed rail by Resident/Legal guardian/ Responsible Party. The documentation was requested from the facility administrator.
During an interview on / at 1:00 PM, the facility administrator acknowledged, Resident #4 did not have a physician order or informed consent for the use of half bed rails on record for review. No documentation was provided to surveyor on /

Class III

0160 Records - Facility

Based on record review, observation and interview, the facility failed to have an updated Admission/Discharge log.

Findings included:

Record review on / found the facility's Admission/Discharge log was not up-to-date. Review of the log found Resident #6's name was not listed.
Observation on / at 11:00 am revealed, the Administrator searched each page of the Admission/Discharge log, and Resident #6's name was not written.

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Record review on / revealed, the facility census (Residents' names and #) dated on showed Resident #6 resided in 505.
Record review on / revealed Resident's chart has a document titled as discharge summary (dated), and it reflected Resident #6 was admitted on and discharged on .
Interview on / at 11:00 am revealed, the Owner confirmed that the Admission/Discharge log did not have Resident #6 recorded.
Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on observation, record review and interview, the facility failed to report an initial adverse incident report within one business day after the incident and full adverse incident report within 15 days of the incident for 2 out of 7 (#4 and #6) sampled residents.
Findings included:
1. During an interview on / at 11:47 am, the Administrator stated that she did not send the Agency for Health Care Administration (AHCA) an incident reports since she started working at the facility as the Administrator. She also stated that not all incidents have to be sent to AHCA, such as or due to falling.
Per the Administrator, the facility has no policy and/or procedure regarding incident reports, however, the Administrator presented the Initial Adverse Incident Report to submit within 1 business day after the incident, and the full adverse incident report within 15 days of the incident.
On / at 9:15 AM, during the facility tour, Resident #4 was observed in B seated in a recliner sofa with a foot on her right leg.
During resident record review on / it was noted Resident #4 was admitted on and had a health assessment dated / / with diagnoses of D deficiency, High , Lumbar Myelopathy, polymyalgia , pigmentosa reticularis, Legally , physical or sensory limitation ambulate with walker and nursing medication management.
Activities of daily living (ADLs) was independent with ambulation, dressing, eating, self-care, toileting, transferring and need assistance with bathing. Special diet instructions: regular/no added salt. Need assistance with self-administration of medications. A Physician telephone order dated / / documented, "SN (skilled nurses) to eval and treat to right elbow cleanse NS (normal) apply TAO cover adaptic gauze, secure, tegaderm 3X wkly /OT (physical and occupational) eval + treat. Signature of nurse (M) verbal orders read back. Hospital Bed with half side rails for safety."
Furthermore Resident #4 went to the Emergency / . The diagnosis was: "Multiple closed of bone, right, initial encounter." Problem list: T11 , Myopathy, . On / /, Resident #4 was admitted to the medical center and was discharged on ." The discharge diagnoses was: . On at 1:48PM, Fire

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Rescue was dispatched and arrived at the facility on at 14:31 and documented history (HX) of present cause: / Slipped/ Tripped. Complaint: head pain. On Resident #4 was admitted to the hospital with diagnoses of Head Injury ... "should follow up with physician in 1 day.

On / Resident #4 was transferred to the Hospital with diagnoses to include: head injury, and , ... you should follow up with the physician in 2 days.

On / the facility's Occurrence Report was reviewed and the facility did not have an incident reported for Resident #4 for any of the that occurred at the facility.

During an interview on / at 9:20 AM, Resident#4 stated, I have been living here for 3 years. She stated, I did here a few times "maybe five times." She stated, she in the . She stated, I want the facility to repair my . She stated, I'm scared of the bathtubs. I take showers on the toilet with clothes/towels. She stated, the certified nursing assistance (CNA) showed me how to do it. She stated, I now have a in my rights foot. She stated, I was a very independent person and now I need to learn how to slow down. She stated, my husband two times here.

Facility agreement reflect Risk Acknowledgement that states, " I, the undersigned, understand that the Resident is considered " at risk" for based on a health assessment and prior medical history. I also understand that a may have severe consequences and result in injuries including lacerations, broken bones and even .

2. Record review revealed Resident #6's personal file documented a hospitalization on and had the following information:

Discharge diagnosis:

" (Patient) was brought to ER (emergency) from the ALF (Assisted Living Facility), was noted by the ALF Staff to have facial . was admitted and evaluated, she had a lump on the left side of forehead, C/Scan (Computed Tomography Scan) of the face showed that had hematoma of the left side of head and had AC. of the Roof of the Right Orbit. Patient has and she is not able to give any information. "

The Form 1823 dated on / documented, on page #1, Resident medical diagnosis reflected no known , , and Chronic Kidney . Resident has memory problems, , disoriented, unable to administer her own medications + needs help with her daily living activities. Resident has , sometimes gets , unable to live independently and has . Resident needs administration of medications including , checking her sugar, 3x daily, preparation of diet, assistance with daily living activities. Patient has and has been used to getting out of her house.

Form 1823 on page #2 reflects that Resident needs assistance for bathing, dressing and . Resident needs supervision on ambulation and toileting. Resident needs total assistance for transferring. Resident is a independent eater. Resident special diet instruction reflects diet, no added salt, low fat/low , low and low diet. Resident has a diagnosis of communicable has Chronic , and it stated that Resident required 24-hour nursing or care.

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The resident had . However, the 1823 Form documented the Resident needs can be met in the facility. In comparison, the Form 1823 signed on reflected, " Resident's needs cannot be met by facility due to Patient should be in a facility where there is nursing care and supervision. needs to be administrated + sugar has to be check regularly. The Progress notes dated on / documents, "Resident observed by Home Health Nurse and facility staff at dining table (while getting ready for lunch) with head down on the table very observed to both eyes. Doctor immediately called orders received transfer to emergency evaluation. Son notified. .... resident transported to ER. On /, a Meeting with [ ] is sister and Exec Dir [ ]. [ ] stated, "Mom has a fx in her face. Someone is going to pay." " Exec Dir handled meeting will have investigation done. On /, received call from social worker of Hospital states," Resident #6 is being discharged today back to CCL. "This write advise her to speak with family as they stated, " We are not happy with the services CCL is providing."
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Am Grand Court Lakes, Llc
280 Sierra Drive
North Miami Beach, FL 33179

RE: CCR #2015011376

Dear Administrator:

This letter reports the findings of a Complaint 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 Kristal Branton, Health Facility Evalautor Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

XG90

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