| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11953670 | R<br>11/23/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**SOUTH DEERING RETIREMENT HOME,** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9730 SW 160 STREET**<br>**MIAMI, FL 33157** | |

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

**0000 Initial Comments**

A Complaint (CCR 2015009257) Survey Revisit was conducted on 11/23/15. South Deering Retirement Home had the following deficiencies at the time of survey:

**0008 Admissions - Health Assessment**

Based on record review and interview the facility failed to have a completed health assessment for 1 out of 5 (Resident #7) sampled residents.
Findings included:
Record review on / showed that Resident #7 (admitted on ) did not have a completed health assessment form (AHCA Form 1823). The form on record did not have the resident's weight, name and signature of the physician and was not dated.
Phone interview on / 1:15 PM with facility Manager/ Owner, she acknowledged the form was not completed.
Class III

**0077 Staffing Standards - Administrators**

Based on record review and interview the facility failed to appoint in writing a separate manager for each facility to assist in the operation and maintenance of those facilities.
Findings included:
Record review on / showed the facility's Administrator (Staff A) supervised two facilities. Record review found the facility's manager (Staff B) did not passed core training test. The facility manager did have the Core Training dated on .
Phone interview on / at 10:54 AM, the Manager stated "I did not passed the Core training test." She also stated "I needed to have the same qualification Administrator?"
Uncorrected Class III

## State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| AL11953670 | A. Building<br>B. Wing | 11/23/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| SOUTH DEERING RETIREMENT HOME, | 9730 SW 160 STREET<br>MIAMI, FL 33157 |

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 **A0030**<br>Reg. # **58A-5.0182(6) FAC; 429.28**<br>LSC | Correction Completed | ID Prefix **A0161**<br>Reg. # **429.275(2) FS; 58A-5.024(2**<br>LSC | Correction Completed | ID Prefix **A0162**<br>Reg. # **58A-5.024(3) FAC**<br>LSC | Correction Completed |
| ID Prefix **AZ827**<br>Reg. # **408.812, FS**<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| | | | | | |
|---|---|---|---|---|---|
| **Reviewed By State Agency** | **Reviewed By** | **Date:** 12/16/15 | **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
South Deering Retirement Home,
9730 Sw 160 Street
Miami, FL 33157

Dear Administrator:

This letter reports the findings of a complaing 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.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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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