| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11963972 | 12/17/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**ROYAL OF KENDALL ACLF INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**12201 SW 93 STREET**<br>**MIAMI, FL 33186** | |

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

**0000 Initial Comments**

A Standard Biennial Survey was conducted on / . Royal of Kendall ACLF Inc had the following deficiencies found at the time of the survey:

**0010 Admissions - Continued Residency**

Based on observation, record review, and interview the facility failed to ensure that 1 out of 5 (Resident #4) sample residents met continued residency criteria.

Findings as follow:

On / at 8:25 a.m. in # , Resident #4 was observed in bed sleeping. The resident observed to have contracted feet and rigid knees. On at 8:50 a.m. observed Staff C (trainee) lifting the resident and sitting her on the commode in the . Resident #4 did not assist during the process.
Record review showed Resident #4's health assessment stated the resident needed total assistance with transferring.
On / at 9:40 a.m. Staff B and Staff C( trainee) stated Resident #4 could not walk and could not assist when transferring.
On / at 12:42 p.m. the facility administrator acknowledged that Resident #4's health has declined and can not transfer with assistance.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Royal Of Kendall Aclf Inc
12201 Sw 93 Street
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a standard biennial licensure 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 , 2016.** 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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