STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942728	**12/15/2015**
NAME OF PROVIDER OR SUPPLIER **ASSISTED LIVING RETIREMENT HOMES I**	STREET ADDRESS, CITY, STATE, ZIP CODE **132 -134 NW 17 COURT** **MIAMI, FL 33125**	

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

0000 Initial Comments

An Abbreviated Biennial survey was conducted on , 2015. Assisted Living Retirement Homes had the following deficiencies at time of the survey:

0077 Staffing Standards - Administrators

Based on observation, record review, and interview the facility failed to ensure their designated Manager did not serve as an Administrator of another facility.

Findings included:

Observation on / from 10:00 am - 2:30 pm revealed Administrator and/or Manager were in the facility at time of survey.

Record review on / revealed facility health finder website showed the current Administrator supervised three facilities. Record review also found the appointed Manager for the facility was also the Administrator at another location.

Interview on / the Administrator stated, "I am Administrator of three facilities; however, each facility have a designated Administrator." Administrator also stated, Staff B is the Administrator assistant for a sister location"

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Assisted Living Retirement Homes I
132 -134 Nw 17 Court
Miami, FL 33125

Dear Administrator:

This letter reports the findings of an abbreviated 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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