STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967313	12/22/2015
NAME OF PROVIDER OR SUPPLIER **SERENE LIVING FACILITIES**	STREET ADDRESS, CITY, STATE, ZIP CODE **8615 SW 43RD TERRACE** **MIAMI, FL 33155**	

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

0000 Initial Comments

A Complaint (CCR#2015012466) Survey was conducted on . Serene Living Facilities with Limited Mental Health and Limited Nursing Services components had the following deficiencies at the time of the survey:

0120 Fiscal - Financial Stability

Based on record review and interview the facility failed to show proof of financial stability.

Findings included:

On / at 9:00 am record review found the facility could not provide documentation to prove financial stability. Bank statements for the last six months was requested from the facility but were not provided during the survey

On / at 11:00 AM during an interview the Administrator stated that he usually had all the statement in the facility but at this point in time all those documents were at his house.

Class III

0162 Records - Resident

Based on record review and interview the facility failed to ensure that one out of three (#3) sampled residents had documentation of a power of attorney (POA), surrogate, or guardianship.

Findings included:

On at 9:35 AM record review found Resident #3's niece signed her contact without having a POA, surrogate, or guardianship documentation.

On at 11:30 AM during an interview the Administrator stated the niece of the resident told him that she had a POA at home and that she was going to bring him a copy. The Administrator stated that this was not the facility's fault because he trusted that the niece was going to provide the documents.

Class III

0167 Resident Contracts

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on record review and interview the facility failed to provide a refund to 1 out of 3(Resident #1) sampled residents based on their refund policy.
Findings included:
On __/__ at 7:58 AM Resident #1's niece stated that up to now she has not received any refund.
On __/__ at 10:00 AM record review showed Resident #1's contract for $1500 was signed on __/__/__ by niece prior to admission to the facility. Resident #1's contract stated "if after a contract is terminated, the facility shall make a claim against a refund due to a resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide the said party a reasonable time period of no less than 14 (fourteen) calendar days to respond." There was no documentation provided by the faiclity to claim Resident #1's deposit.
On __/__ at 10:30 AM during an interview the Administrator stated Resident #1's niece had been coming to the facility to see it and she liked it very much, the last time that she came to the facility was on __/__/__. He explained to her that she had to make a decision because he had other residents waiting to be admitted to the facility, and she told him that she was going to give him the deposit of $800.00 out of the $1500.00. According to the Administrator the complainant provided the deposit payment of $800.00 in cash thus he cannot provide prove of deposit because the money was used to pay some bills. They signed the contract but at the end of the month she called him back to let him know that she had changed her mind and that her aunt was not going to be place in the facility.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Serene Living Facilities
8615 Sw 43rd Terrace
Miami, FL 33155
RE: CCR #2015012466

Dear Administrator:

This letter reports the findings of a complaint 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

XG90

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