STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910987	**01/06/2016**
NAME OF PROVIDER OR SUPPLIER **MAGGIE'S RETIREMENT HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **7930 SW 11 STREET MIAMI, FL 33144**	

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

0000 Initial Comments

An extended congregate care monitoring survey was conducted on , 2016. Maggie's Retirement Home with Extended Congregate Care and Limited Mental Health components had the following deficiency identified at the time of survey:

0077 Staffing Standards - Administrators

Based on record review and interview, the Assisted Living Facility whose administrator supervised two assisted living facilities failed to appoint in writing a separate manager who did not serve as an administrator of any other facility.

Findings included:

1. Record review of the Florida Health Finder website on I/ showed that Administrator supervised two assisted living facilities. Review of facility's record revealed that the Manager was hired on . Review of the Florida Health Finder website found the Manager served as an Administrator of other assisted living facility.

2. In a phone interview on I/ at 1:58 PM the Manager revealed that she was Administrator of another facility and she thought that she could be the Manager of two other facilities at the same time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Maggie's Retirement Home
7930 Sw 11 Street
Miami, FL 33144

Dear Administrator:

This letter reports the findings of an extended congregate care monitoring licensure survey that was conducted on , 2016 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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