

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/25/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967208	(X3) DATE SURVEY COMPLETED R / /
NAME OF PROVIDER OR SUPPLIER VENETIAN ISLES ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 3003 SW 156 PLACE MIAMI, FL 33185	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on 01/13/16. Venetian Isles Alf had the following deficiencies at time of survey:

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews the facility failed to treated one out three (#4) residents sampled with consideration, respect and with due recognition of personal dignity, individuality, and the need for privacy.

Findings included:

During the facility tour on 1/13/16 at 12:00 PM observed in room #4. Resident #4 asleep in a bed with full bed rails attached to both sides. Further observations found a complete off white bedspread that included single bed, chest door, and dresser.

During the tour on 1/13/16 at 12:03 PM Staff D (caregiver) stated this is my bed. She stated I slept here and this is my room. She stated I brought it here because I live here 24 hours. She stated I have one day off.

On 1/13/16 during exit conference with Staff B and Staff D, both staff acknowledged that staff shared a room with residents. Staff D stated I slept sometimes in room #4. She stated most of the time I sleep in the sofa in the common area or in the living room. She stated I'm scared that the resident will fall. Staff B stated I did not want to put a bed in the common area.

Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967208	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2	Y3
NAME OF FACILITY VENETIAN ISLES ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 SW 156 PLACE MIAMI, FL 33185	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0010	Correction	ID Prefix A0052	Correction	ID Prefix A0083	Correction
Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.0191(4) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0161	Correction	ID Prefix A0162	Correction	ID Prefix	Correction
Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 58A-5.024(3) FAC	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>CS</i>	DATE 11/25/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/12/2015		☐ 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

, 2016

Administrator
Venetian Isles Alf
3003 Sw 156 Place
Miami, FL 33185

Dear Administrator:

This letter reports the findings of a standard biennial revisit survey conducted on 2016 by 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**

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

