| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966372 | 01/13/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**MIRAMAR SENIOR LIVING** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**14833 SW 24 STREET**<br>**MIAMI, FL 33185** | |

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

**0000 Initial Comments**

A Complaint (CCR#2015012223) Survey was conducted on / . Miramar Senior Living with a Standard License had the following deficiency at the time of the survey:

**0079 Staffing Standards - Levels**

Based on observation, record review, and interview the assisted living facility failed to maintain a written work schedule which reflects its staffing pattern for a given time period.

Findings Included:

On / / at 9:05 AM during the tour was found one staff member providing services to a census of 5 residents. The Administrator arrived to the facility on / at 10:00 AM.

On / at 9:10 AM record review of the facility's staffing schedule found the staff schedule for month of . The facility did not have the staffing schedule for .

On / / at 11:30 AM during an interview with the Administrator, he stated he was going to make sure that the schedule was going to be corrected.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Miramar Senior Living
14833 Sw 24 Street
Miami, FL 33185
**RE: CCR #2015012223**

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was conducted on 13, 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

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Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com