STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910710	03/24/2016
NAME OF PROVIDER OR SUPPLIER **MERRIMENT MANOR RETIREMENT HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1835 WILSON STREET HOLLYWOOD, FL 33020**	

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

0000 Initial Comments

An unannounced licensure complaint (CCR# 2016002759) was conducted from 3-18-16 to 3-24-16. The Merriment Manor Retirement Home assisted living facility had deficiencies identified at time of the visit.

L241 LMH - Records

Based on interview and record review, the facility failed to have a copy of 5 out of 5 residents' (residents # 1, 2, 3, 4 and 5) community living support plan to demonstrate coordinated mental health services to its residents.

The findings included:

Review of Resident #1, #2, #3, #4 and #5's records indicated that they were limited mental health residents that lived in the facility for longer than 30 days. Further review of the residents' records indicated that the facility failed to have completed community living support plans for Residents #1, #2, #3, #4 and #5.

During an interview with the Administrator on - - at 1:30pm, she stated that the facility did not ensure updated individual community living support plans for Residents #1, #2, #3, #4 and #5 because she believed that they were not required.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
Merriment Manor Retirement Home
1835 Wilson Street
Hollywood, FL 33020

RE: CCR #2016002759

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at 561-381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dlt
Enclosure

XG90

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