STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967222	R
NAME OF PROVIDER OR SUPPLIER **MGR HOME, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5305 SW 137 CT** **MIAMI, FL 33175**	

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

0000 Initial Comments

A Standard Biennial Survey revisit was conducted on . MGR Home with Limited Mental Health component had the following deficiencies found at time of survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint in writing a separate manager for each facility, the facility's Administrator supervised more than one assisted living facility (ALF) and the facility's Manager was the Administrator of another ALF.
Findings as follow:
Record review on showed the facility's appointed Manager was the Administrator of another ALF. The facility did not have a separate Manager for each location the Administrator supervised.
On at 11:00 AM, the facility's Administrator stated "I'm the Administrator of two ALFs" and added she was not aware the manager supervised another facility.
Uncorrected Class III

0162 Records - Resident

Based on record review and interview the facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one out of six (Resident #1) sampled residents.
Findings as follow:
Record review on showed the contract between Resident #1 and the facility was signed by a family member. Record review showed the facility failed to have a health care surrogate appointed, health care proxy, guardian or a power of attorney for review.
On at 11:00 AM, the facility's Administrator acknowledged the facility failed to have a health care surrogate appointed, health care proxy, guardian or a power of attorney for resident #1.
Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967222 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MGR HOME, INC	5305 SW 137 CT MIAMI, FL 33175

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 A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) JS	DATE 4/11/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: MSW512

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Mgr Home, Inc
5305 Sw 137 Ct
Miami, FL 33175

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 11, 2016.**

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

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