

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 04/22/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967313	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER SERENE LIVING FACILITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 8615 SW 43RD TERRACE MIAMI, FL 33155	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on [redacted], 2016. Serene Living Facilities had a deficiency identified at time of survey.

N277 LNS - Resident Care Standards

Based on record review and interview the facility failed to employ or contract a nurse to provide Limited Nursing Services.

Findings included:

Record review revealed the facility had a contract with a Registered Nurse to provide Limited Nursing Services as needed that was signed on [redacted].
On [redacted] / [redacted] at 10:17 am the Registered Nurse stated on the phone that she is not longer contracted by the facility.
The facility's Administrator stated on [redacted] at 1:30 pm that the Registered Nurse did not want to continue working in the assisted living facilities and that he had to find a new nurse because nobody wants to do Limited Nursing Services at the facilities any more.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Serene Living Facilities
8615 Sw 43rd Terrace
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a Limited Nursing Services 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

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



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida