STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967296	04/11/2016
NAME OF PROVIDER OR SUPPLIER **MAGNET ADULT HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1431 NW 55 TERRACE** **MIAMI, FL 33142**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2016. Magnet Adult Home with Extended Congregate Care component had deficiencies identified at the time of the survey.

0010 Admissions - Continued Residency

Based on record review and observation the facility failed to conduct a new face-to-face medical examination as part of the continuing residency criteria after a significant change in the activities of daily living for one out of six sampled residents (Resident #1).

Findings included:

On / from 8:30 am to 2:15 pm during the time of the survey found Resident #1 able to freely move her hands and arms and able to fix her clothes and eat.

Record review of Resident #1's record found her health assessment was completed on and stated that resident required total assistance with eating, , and bathing due to the fact that the resident is legally .

Class III

0080 Training - Core & Competency Test

Based on record review and interview the facility's Manager failed to participate in 12 hours of continuing education in topics related to assisted living every 2 years.

Findings included:

Record review of the Manager's record revealed the core certification was dated . Record review found the facility did not have any evidence the Manager received 12 hours continuing education in topics related to assisted living.

The facility's Manager stated over the phone on / at 1:30 pm that she was a certified trainer and that she had sent her credentials to the agency last year.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967296	**04/11/2016**
NAME OF PROVIDER OR SUPPLIER **MAGNET ADULT HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1431 NW 55 TERRACE MIAMI, FL 33142**	

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

0162 Records - Resident

Based on record review and interview the facility failed to have a copy of the written informed consent for unlicensed staff to assist with self-administration of medications for 1 out of 6 sampled residents (Resident # 5).

Findings included:

Record review of Resident #5's revealed that there was not an informed consent for assistance with self-administration of medications by unlicensed staff available for review.

The facility's Administrator stated on / at 1:55 pm that he did not know what happened to the consent because Resident # 5 had been in the facility for a long time and maybe when the resident was admitted the regulations were different. He also stated that he will get the form and will have Resident # 5 to sign it.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Magnet Adult Home
1431 Nw 55 Terrace
Miami, FL 33142

Dear Administrator:

This letter reports the findings of a Standard Biennial 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