STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966977	04/20/2016
NAME OF PROVIDER OR SUPPLIER **SILVER PALM ALF CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **11271 SW 229 TERRACE** **MIAMI, FL 33170**	

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

0000 Initial Comments

A Standard Biennial survey was conducted on . Silver Palm ALF Corp with Limited Mental Health component had a deficiency found at the time of the survey.

0093 Food Service - Dietary Standards

Based on observations, record review, and interview the assisted living facility failed to have a doctor's order for 1 out of 4 (Resident #2) sampled residents' diets.

Findings include:

Lunch observations on at 12:00 PM found that Staff C served Resident #2 puree lunch.

Record review found that the facility did not have a doctor's order for Resident #2's puree diet.

Interview conducted on at 1:45 PM, the Administrator stated " I'm going to contact Resident #2's physician to obtain a doctor's order for the puree diet."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Silver Palm Alf Corp
11271 Sw 229 Terrace
Miami, FL 33170

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

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