STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911859	R 05/02/2016
NAME OF PROVIDER OR SUPPLIER: SENIOR RETIREMENT HOME, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 3033 SW 6 STREET MIAMI, FL 33135	

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

0000 Initial Comments

A Standard Biennial Second Revisit Survey was conducted on 5/2/16. Senior Retirement Home, Inc had the following deficiency identified at the time of the survey:

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint a separate Manager for each facility, the Administrator supervised two assisted living facilities.

Findings included:

On ../ . at 10:30 am Staff E stated, "I am the Owner and manager of the facility" Staff E then stated "Staff D is the Manager of this facility."

Review of the background screening's clearinghouse employee roster showed Staff E was listed as an employee at six assisted living facilities.

Interview with Staff D on ./ . at 12:20 pm revealed that she is the Manager at a sister location that Staff E is also the Administrator.

The facility finder had Staff A (Administrator of the facility) and Staff E (owner of the facility) are the Administrators of two assisted living facilities each.

Record review found the facility failed to appoint a separate Manager for each facility the Administrator supervises.

Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11911859 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR RETIREMENT HOME, INC	3033 SW 6 STREET MIAMI, FL 33135

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 A0010 Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC LSC	Correction Completed	ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS LSC	Correction Completed	ID Prefix A0052 Reg. # 58A-5.0185 (3) LSC	Correction Completed
ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed	ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed
ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed	ID Prefix A0082 Reg. # 58A-5.0191(3) FAC LSC	Correction Completed
ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed	ID Prefix A0161 Reg. # 429.275(2) FS; 58A-5.024(2) FAC LSC	Correction Completed
ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed	ID Prefix AZ813 Reg. # 59A-35.090(3)(c), FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 5/11/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/18/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Senior Retirement Home, Inc
3033 Sw 6 Street
Miami, FL 33135

Dear Administrator:

This letter reports the findings of a Standard Biennial **second** licensure revisit survey conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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** .

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

YOSF

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