STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967256	**05/09/2016**
NAME OF PROVIDER OR SUPPLIER **SUBLIME ATARDECER INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **20630 NW 37 CT** **MIAMI, FL 33055**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2016. Sublime Atardecer Inc. with Limited Mental Health component had a deficiency identified at the time of the survey.

L241 LMH - Records

Based on record review and interview the facility failed to have an annual Community Living Support Plan for 1 out of 6 limited mental health residents (Resident # 3).

Findings included

Review of the admission and discharge log revealed Resident #3 was identified as a limited mental health resident.

On at 11:30 am the facility's Administrator identified all residents as limited mental health.

Record review of Resident #3's record revealed the annual Community Living Support Plan was signed on .

On at 12:20 pm the facility's Administrator stated that Resident #3's case manager took the papers with her to sign them and did not return them to the facility.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sublime Atardecer Inc
20630 Nw 37 Ct
Miami, FL 33055

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 Arlene Mayo-Davis, RN.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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