STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967319	06/15/2016
NAME OF PROVIDER OR SUPPLIER **SILVER DAYS ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **8823 SW 151 COURT** **MIAMI, FL 33196**	

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

0000 Initial Comments

A Limited Mental Health Component Expansion Survey was conducted on and concluded on . Silver Days ALF, license 11376) with a standard license had a deficiency found at the time of the survey.

Z827 Unlicensed Activitv

Based on observation, record review, and interview the facility exceeded its license capacity by providing care and services to eight residents over a 24 hour period. The facility is licensed for six beds.

Findings included:

On at 8:06 AM observations during the tour found Residents #7 and #8 sitting in the living and dressed.

On at 8:06 AM Staff A stated, "these are daycare participants, but every now and then they stay overnight because the family member cannot come and pick them up."

On at 8:42 AM during an interview with Residents #1, #2, #5, and #6 stated the same amount of residents that are here are always there.

On at 10:30 AM during an interview with Caregivers C and D, they both stated that this information was going to be given to the Administrator and these two participants will not stay overnight again.

Unclassified Deficiency

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Silver Days Alf
8823 Sw 151 Court
Miami, FL 33196

Dear Administrator:

This letter reports the findings of a Limited Mentalh Health component expansion licensure survey that was concluded 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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