STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965854	**07/07/2016**
NAME OF PROVIDER OR SUPPLIER **SUANY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **20411 SW 116 ROAD MIAMI, FL 33189**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on and concluded on . Suany's Home with Limited Mental Health component, license AL10173, has the following deficiency at the time of the survey:

0010 Admissions - Continued Residency

Based on observation, record review, and interview the facility failed to have an accurate health assessment, showing changes in 1 out of 6 (Resident #1) sampled residents' condition.

Findings as follow:

On at 8:45 and at 2:50 p.m. Resident #1 was observed in bed with full bed rails up.

Record review showed the health assessment of Resident #1 stated, resident needed assistance with ambulation, transferring, dressing and bathing, supervision with and toileting and is independent, eating. Record review also showed Resident #1 is under hospice services.

On at 8:45 a.m. and .2016 at 2:50 p.m. the facility's administrator stated, Resident #1 is bed bound, under hospice care, adding a hospice certified nursing assistant (CNA) gives total assistance to resident with bathing and dressing. The facility's administrator stated the facility had no a health assessment for this resident showing the change in condition.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Suany's Home
20411 Sw 116 Road
Miami, FL 33189

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