STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967256	R / /
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 Revisit Survey was conducted on 01, 2016. Sublime Atardecer Inc. (Facility license # 11299) with Limited Mental Health component had deficiencies identified at the time of the survey.

0025 Resident Care - Supervision

Based on record review and interview the facility failed to have written records regarding any illnesses that resulted in hospitalization for one of five residents (#3).

Findings included

Observation on / at 12:08 pm revealed that there were four residents in the facility at the time of survey.

Record review of the Admission/Discharge log reflected five residents living in the facility.

Record review of Resident #3's Medication Observation Record (MOR) showed that he was in the hospital on . Resident #3's progress notes available for review were date from to / . The facility did not have any information regarding Resident #3's hospitalization.

Interview on / at 1:00 pm the Administrator stated, "I do not have any written information that explained Resident #3 hospitalization because I am waiting on the Consultant to do it; she comes monthly to the facility."
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview the facility failed to provide a safe living environment and an environment free of hazards.

Findings included:

During the facility tour on / at 12:20 pm revealed the backyard had a lot of debris include wood and metals. Also, there were seven cats living at the backyard at the time of the survey, the facility did not have any records for the cats.

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

Interview on / / at 1:20 pm the Administrator stated, "I will organize the backyard; we are doing some repairs and soon is done, the debris will be picked up. " Also Administrator stated, " The cats do not belong to me, but I do not know how to take them out of the backyard. "

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967256 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLIME ATARDECER INC	20630 NW 37 CT MIAMI, FL 33055

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 AL241 Reg. # 429.075(3-4); 58A-5.029(2) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) [signature]	DATE 7/12/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/9/2016	☐ 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
Sublime Atardecer Inc
20630 Nw 37 Ct
Miami, FL 33055

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

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 , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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