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 2nd Revisit Survey was conducted on 24, 2016. Sublime Atardecer Inc. (Facility license #11299) with Limited Mental Health component had a deficiency identified at the time of the survey.

0167 Resident Contracts

Based on record review and interview the facility failed to have a monthly payment reflected on the contract for one of six (6) sampled residents.

Findings included:

Observation on at 3:30 pm revealed Resident #6 lived in #.

Record review on revealed Resident #6 had a signed contract dated on / ; however, it did not reflect a monthly payment at time of survey.

Interview on at 4:00 pm Staff A confirmed that Resident # 1 did not have the monthly payment reflected in his contract because she had been waiting on the Social Worker's Program.

Class III

Z813 Results of Screening & Notification in File

Based on record review and interview the facility failed to have a completed and signed attestation in personnel files.

Findings included:

Observation on at 3:30 pm showed facility's updated staffing pattern reflected Staff D.

Record review on revealed Staff 's D have her backgrounds screening in file, but the attestation for staff D was missing.

During an interview on at 3:43 pm Staff A acknowledged that Staff D (hired on / /) did not have attestation in her file.

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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)

Unclassified Deficiency

Z814 Background Screening Clearinghouse

Based on record review and interview, the facility failed to register staff through the clearinghouse.

Findings included:

Review on the background screening's website revealed Staff D was not included in the facility's roster.

Interview on at 3:40 pm Staff A confirmed that Staff D started to work in the facility on Staff A stated that she will add Staff D in the facility's roster in the clearinghouse.

Unclassified Deficiency

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 A0025 Reg. # 429.26(7) FS; 58A-5.0182(1) FAC LSC	Correction Completed	ID Prefix A0152 Reg. # 58A-5.023(3) 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	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) VC	DATE 9/7/14	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 **second** Standard Biennial Licensure Revisit Survey conducted on
24, 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 , 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(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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