

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/06/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910968	(X3) DATE SURVEY COMPLETED 08/11/2016
NAME OF PROVIDER OR SUPPLIER NORTH MIAMI RETIREMENT LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1595 NE 145 STREET NORTH MIAMI, FL 33161	

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

0000 Initial Comments

A Financial Monitoring survey was conducted at North Miami retirement Living on - | - . There was a deficiencies found at the time of the survey. (Lic# 5934)

0010 Admissions - Continued Residency

Based on record review and interview the facility failed to have one out of four sampled residents' (#1) completed Health Assessment (1823).

Findings included:

Record review revealed Resident #1's last health assessment (1823) dated was found to be incomplete. The health assessment did not document the level of assistance needed for activities of daily living or have other the other sections completed on the health assessment.

Interviewed the Administrator on - | - at 11:00 AM, she confirmed the findings in regards to Resident #1's health assessment being incomplete.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2016

Administrator
North Miami Retirement Living
1595 Ne 145 Street
North Miami, FL 33161

Dear Administrator:

This letter reports the findings of a Financial Monitoring licensure survey that was conducted on [redacted], 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 [redacted], 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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