STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966372	R
NAME OF PROVIDER OR SUPPLIER **MIRAMAR SENIOR LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **14833 SW 24 STREET** **MIAMI, FL 33185**	

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

0000 Initial Comments

A Complaint (CCR#2015012223) Survey 3rd Revisit was conducted on 08/09/2016. Miramar Senior Living (license #10593) had deficiencies identified at the time of the visit related to another complaint survey.

0010 Admissions - Continued Residency

Based on observation, record review, and interview the facility failed to have an accurate health assessment for 1 out of 5 (Resident # 4) facility residents.

Findings as follow:

On at 10:55 a.m. Resident #4 was observed talking to resident #3. Resident #4 was observed walking in facility, also observed talking to Staff about daily matters. On at 11:55 a.m. Resident #4 was observed sitting at the dining table eating lunch. Resident #4 was observed to performing activities of daily living (ADLs) independently.

Health Assessment dated stated resident needed assistance with all ADLs.

On at 1:00 p.m. Staff B (caretaker) stated resident #4 did not need assistance with ADLs and needed supervision.

On at 1:10 p.m. Resident #4 stated he bath, dress, eat without assistance.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Miramar Senior Living
14833 Sw 24 Street
Miami, FL 33185

Dear Administrator:

This letter reports the findings of a Complaint licensure survey 3rd 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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966372 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRAMAR SENIOR LIVING	14833 SW 24 STREET MIAMI, FL 33185

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 A0030	Correction	ID Prefix A0052	Correction	ID Prefix A0053	Correction
Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.0185(4) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0054	Correction	ID Prefix A0162	Correction	ID Prefix AZ814	Correction
Reg. # 58A-5.0185(5) FAC	Completed	Reg. # 58A-5.024(3) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 9/9/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/13/2016	☐ YES ☐ NO