STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910416	R
NAME OF PROVIDER OR SUPPLIER **SWANKRIDGE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **122 NW 7 STREET** **HOMESTEAD, FL 33030**	

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

0000 Initial Comments

A complaint (CCR# 2016006093) revisit survey was conducted on , 2016. Swankridge, Inc. with standard license and license number 5184 had the following deficiencies identified at the time of the survey:

0054 Medication - Records

Based on observation, record review, and interview, the Assisted Living Facility's failed to immediately updated each time the medication is offered or administered for seven (Residents #1, #2, #3, #4, #5, #6, and #7) out of seven sampled residents.

Findings included:

Observation on at 9:05 AM revealed that Caregiver A grabbed the medication book and attempted to start initialing it.

Review of medication observation book revealed that medicines scheduled at 8 AM on for Residents #1, #2, #3, #4, #5, #6, and #7 were not initialed by any staff member after Residents #1, #2, #3, #4, #5, #6, and #7 received assistance with self-administration of medications.

In an interview on at 9:13 AM Caregiver A stated " I am busy busy, I am sorry".

Class III

Z814 Background Screening Clearinghouse

Based record review and interview, the Assisted Living Facility failed to maintain the employment status of all employees within the clearinghouse and any changes in status must be reported within 10 business days.

Findings included:

A review of the facility's account on the background screening clearinghouse website was conducted on . The section titled "Employee Roster" had one staff member, Caregiver F with hire date and no end date.

Review of Caregiver A's personnel filed revealed that hire date was

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of Caregiver B's personnel filed revealed that hire date was [illegible].
Review of Caregiver C's personnel filed revealed that hire date was [illegible].
Review of Caregiver D's personnel filed revealed that hire date was [illegible].
Review of Caregiver E's personnel filed revealed that hire date was [illegible].

In an interview on [illegible] at 9:31 AM Chief Financial Officer revealed that Caregiver F just worked for a couple of days and did not work in the facility anymore; also Chief Financial Officer revealed that did not know about employer roster.

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11910416 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANKRIDGE, INC	122 NW 7 STREET HOMESTEAD, FL 33030

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 Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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) OG	DATE 9/13/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/5/2016	☐ 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
Swankridge, Inc
122 Nw 7 Street
Homestead, FL 33030

Dear Administrator:

This letter reports the findings of a Complaint 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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Miami, FL 33166
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