



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

....., 2016

Administrator
Golden Years For The Elderly Corp
13184 Sw 19 Terrace
Miami, FL 33175

Dear Administrator:

This letter reports the findings of an abbreviated biennial revisit survey conducted on, 2016 by 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,

A handwritten signature in black ink, appearing to read "Arlene Mayo-Davis", is written over a horizontal line.

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

BBT7



**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 10/12/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965545	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS FOR THE ELDERLY CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 13184 SW 19 TERRACE MIAMI, FL 33175	

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

0000 Initial Comments

An Abbreviated Biennial revisit was conducted on _____ at Golden Years for the Elderly Corp. There was a uncorrected deficiency identified at time of survey. (Lic# 9923)

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview facility failed to file an adverse incident report for one of five sampled residents (#3) who was transported to a hospital for a emergent need on _____. Findings included:

Reviewed Resident (#3) chart and the adverse incident log and database. No documentation was provided regarding Resident #3's hospitalization on _____.

Interviewed Administrator on _____ at 10:30 Am. She stated that she did not know that they needed to complete the incident report.

Uncorrected
Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965545	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
NAME OF FACILITY GOLDEN YEARS FOR THE ELDERLY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 13184 SW 19 TERRACE MIAMI, FL 33175

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 A0054	Correction	ID Prefix A0057	Correction	ID Prefix A0084	Correction
Reg. # 58A-5.0185(5) FAC	Completed	Reg. # 58A-5.0185(8) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0152	Correction	ID Prefix AL243	Correction	ID Prefix	Correction
Reg. # 58A-5.023(3) FAC	Completed	Reg. # 429.075(1) FS; 58A-5.0191(8) FAC	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	
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	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/3/2016				
☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO				