STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967327	**01/18/2017**
NAME OF PROVIDER OR SUPPLIER **GOLDEN AGE ALF V, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7861 NORTHWEST 175 STREET** **HIALEAH, FL 33015**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted at your Golden Age ALF V on 01-18-2017. There were deficiencies found at the time of survey. Lic# 11384.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to provide documentation of an updated health Assessment (AHCA Form 1823) which accurately reflected a change of condition for one of six sampled Residents (#4).

Findings included:

Record review revealed that Resident (#4) was now in Hospice care services which started - . The Resident's current 1823 stated regarding her Activities of Daily Living (ADL) that the resident needed assistance with ambulation, bathing, dressing, eating, , toileting and transferring, and that she needed supervision with eating. These assessments were contradicted elsewhere on the 1823, which showed in Section C that the resident was bedridden.

Interviewed on - at 3:00 PM, Caretaker (B) stated that health assessment needed to be updated as soon as possible and that the Administrator would be advise of the needed changes.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Golden Age Alf V, Llc
7861 Northwest 175 Street
Hialeah, FL 33015

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2017 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 , 2017.** 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis-RN
Field Office Manager

AMD/sb
Enclosure
XG90

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