

Agency for Health Care Administration

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953670</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/23/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTH DEERING RETIREMENT HOME,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9730 SW 160 STREET</b><br><b>MIAMI, FL 33157</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 000}                                                                   | Initial Comments<br><br>A revisit to a biennial survey was conducted was<br>conducted at South Deering Retirement Home on<br>and concluded on . A<br>deficiency was identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {A 000}                                                                                      |                                                                                                                          |  |                                                                    |
| {A 152}<br>SS=D                                                           | 58A-5.023(3) FAC Physical Plant - Safe Living<br>Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to<br>Section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and<br>3. Ensure that all existing architectural,<br>mechanical, electrical and structural systems,<br>and appurtenances are maintained in good<br>working order.<br>(b) Pursuant to Section 429.27, F.S., residents<br>must be given the option of using their own<br>belongings as space permits. When the facility<br>supplies the furnishings, each resident bedroom<br>or sleeping area must have at least the following<br>furnishings:<br>1. A clean, comfortable bed with a mattress no<br>less than 36 inches wide and 72 inches long, with<br>the top surface of the mattress at a comfortable<br>to ensure easy access by the resident;<br>2. A closet or wardrobe space for hanging<br>clothes;<br>3. A dresser, or other furniture designed for<br>storage of clothing or personal effects;<br>4. A table or nightstand, bedside lamp or floor<br>lamp, and waste basket; and<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate<br>keys to resident bedrooms to be used in the<br>event of an emergency.<br>(d) Residents who use portable bedside<br>commodes must be provided with privacy during | {A 152}                                                                                      |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953670</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/23/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTH DEERING RETIREMENT HOME,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9730 SW 160 STREET</b><br><b>MIAMI, FL 33157</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 152}                                                                   | <p>Continued From page 1</p> <p>use.</p> <p>(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and interview, the facility failed to maintain a safe living environment to the residents.</p> <p>Findings Include:</p> <p>On . . . . . at 09:55 am, observed a blue plastic tarp covered the roof of the facility.</p> <p>Interview conducted on . . . . . at 10:00 am, Staff A stated that the roof had a leak due to the last hurricane that hit State. Staff A also stated that the facility was working with insurance company to fix the roof.</p> <p>Class III</p> | {A 152}                                                                        |                                                                                                                          |                          |                                                                    |