STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911004	11/24/2015
NAME OF PROVIDER OR SUPPLIER **MILLER HEIGHTS HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **4930 SW 87 AVENUE** **MIAMI, FL 33165**	

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

0000 Initial Comments

An Abbreviated Biennial Survey was made on / . Miller Heights Home had the following deficiencies at the time of visit:

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint a manager for an administrator who supervises three facilities.

Findings as follow:

Record review on / found the facility administrator supervises three facilities. Further review found the facility failed to have documentation of an appointed manager.

On / at 9:00 a.m., the facility administrator stated did not have a manager appointed.

Class III

Z815 Background Screening: Prohibited Offenses

Based on record review and interview the facility failed to ensure one out of three sampled staff who has been screened prior to , 2011 are rescreened by , 2015.

Findings Include:

Record review conducted on / found the administrator, hired , was last background screening was dated .

Interview conducted / at 9:30 AM the administrator acknowledged she needed to be rescreened

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Miller Heights Home
4930 Sw 87 Avenue
Miami, FL 33165

Dear Administrator:

This letter reports the findings of an Abbreviated Biennial SUrvey that was conducted on , 2015 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 , 2015.** 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

XG90

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