STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967407	04/22/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Hostal Nostalgia Alf	**10670 Sw 7 Terrace Miami, FL 33174**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Limited Nursing Services Monitoring Survey was conducted on , 2014. Hostal Nostalgia ALF had the following the deficiency.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and interview, the facility failed to honor resident rights regarding use of restrains for 1 out of 1 sampled residents (# 1).

Findings include:

On at 8:45 am during tour observed in # a bed with half side rail attached.

On at 8:46 am staff # A stated: " Resident # 1 sleeps in # and uses half side rail."

Record review of resident # 1 revealed that resident uses half side rail. Prescription for side rail was written by her primary physician on , no consent for side rail found in resident # 1 record.

On at 9:35 am Staff # 1 stated: "I did not know that I needed a consent for the use a half bed rails. I will talk to resident's sister today to sign a consent for her to use the side rail."

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2014

Administrator
Hostal Nostalgia Alf
10670 Sw 7 Terrace
Miami, FL 33174

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2014 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.

Staff from this office will conduct a review after , 2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 at 305-593-3100.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD:kb
Enclosure
XG90

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