

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966502	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER Manos Amigas Alf	STREET ADDRESS, CITY, STATE, ZIP CODE 8510 Sw 47 Street Miami, FL 33155	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments

An Abbreviated survey was conducted on 08/07/14. Manos Amigas ALF did not have deficiencies identified at the time of the survey.



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

September 8, 2014

Administrator
Manos Amigas Alf
8510 Sw 47 Street
Miami, FL 33155

Dear Administrator:

This letter reports findings of an Abbreviated Biennial survey that was conducted on August 7, 2014 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

1GGN

