STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967521	**11/03/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Palmetto Alf Ii, Inc	**8933 Nw 172nd Hialeah, FL 33018**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments

A Limited Nursing Services Monitoring survey was conducted on , 2014. Palmetto ALF II had a deficiency at time of the survey.

0162-Records - Resident 58A-5.024(3) FAC

Based on observation, record review, and interview the facility failed provide a copy of the health care provider's order for use for 1 out of 3 sampled residents (#3).

Findings included:

Facility tour on at 8:15 am observed an concentrator in # . On at 12:05 pm observed resident #3 having lunch at the dining with nasal cannula attached and the concentrator turned on.

Record review of resident # 3 revealed that the facility did not have an order for the use .

On at 12:15 pm resident #3 stated that she uses the because she has and that she herself is the one administering the and that she has used it since before moving to the facility on .

On at 11:10 am the administrator stated that resident #3 was admitted from rehab with the concentrator but that the original order for was not sent to the facility.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. . . . . , 2014

Administrator
Palmetto Alf li, Inc
8933 Nw 172nd
Hialeah, FL 33018

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring 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 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

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