

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966967	(X3) DATE SURVEY COMPLETED 03/11/2015
NAME OF PROVIDER OR SUPPLIER Natalia Alf Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 2118 Sw151 Place Miami, FL 33185	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 429.26(4-6) Fs; 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Survey was conducted on _____, 2015. Natalia ALF Inc had the following deficiency at time of survey:

0008-Admissions - Health Assessment 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed to have a completed health assessment for 1 out of 5 (#2) sampled residents.

Findings included:

Record review found that the facility did not have a completed health assessment for resident #2. The health assessment dated ____/____/____ did not have documentation resident's weight, height, if resident require 24-hour nursing or _____ care, and if resident need help with taking medication and what type of assistance is need.

Interview on ____/____/____ at 3:00 PM with the Administrator after review of the health assessment verified it was not complete.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Natalia Alf Inc
2118 Sw151 Place
Miami, FL 33185

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on
1, 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.

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

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