State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11966633	A. Building B. Wing	

Name of Facility	Street Address, City, State, Zip Code
LA PURISIMA	100 SW 36 AVENUE CORAL GABLES, FL 33135

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0010 Reg. # 429.26(1&9) FS; 58A-5.018 LSC	Correction Completed	ID Prefix A0028 Reg. # 58A-5.0182(4) FAC LSC	Correction Completed	ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC	Correction Completed
ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed	ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed	ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed
ID Prefix A0056 Reg. # 58A-5.0185(7) FAC LSC	Correction Completed	ID Prefix A0077 Reg. # 429.176 FS; 58A-5.019(1) F LSC	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed
ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed	ID Prefix A0085 Reg. # 58A-5.0191(6) FAC LSC	Correction Completed	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed
ID Prefix A0152 Reg. # 58A-5.023(3) FAC LSC	Correction Completed	ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed	ID Prefix A0167 Reg. # 58A-5.025 FAC LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966633	R
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
LA PURISIMA	**100 SW 36 AVENUE CORAL GABLES, FL 33135**	

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

0000 - Initial Comments

A Complaint Survey Revisit was conducted on 05/21/15. La Purisima, ALF had the following deficiencies found at the time of the survey.

0120 - Fiscal - Financial Stability - 429.17(3) FS: 429.275(1)58A-5.021(1) FAC

Based on record review and interview the facility failed to provide bank statements for the last six months to prove financial stability and potential refunds to residents.

Findings included:

On / at 9:30 AM Record review found the facility could not provide documentation to prove financial stability. Bank statements for the last six months was requested from the facility but were not provided during the survey.

On / at 9:46 AM, according to the administrator, it is very hard for the facility to provide a summarize financial business record, because she mostly does all her payments with cash, she does not use a bank.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observations, record review, and interview the facility failed to have a current, Fire Inspection

Findings included:

On / at 7:34 AM during the tour was observed that the Fire Inspection was not posted where all the other inspections were.

On / at 11:00 AM interview with the administrator, stated that she was going to take care of it immediately, because she had forgotten to do it..

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
La Purisima
100 Sw 36 Avenue
Coral Gables, FL 33135

Dear Administrator:

This letter reports the findings of a Complaint Revisit Survey conducted on May 21, 2015 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

All deficiencies shall be corrected no later than _____.

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

YOSF

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