STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965316	08/04/2015
NAME OF PROVIDER OR SUPPLIER **LEO MAY ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **3666 SW 5TH TERRACE** **MIAMI, FL 33135**	

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

0000 Initial Comments

A Complaint investigation (CCR#2015004704) was conducted on . Leomay ALF Inc. with Limited Mental Health component had the following deficiency found at the time of the survey.

0167 Resident Contracts

Based on record review and interview the facility failed to honor its refund policy for 1 out of 3(Resident #1) sampled residents.

Findings included:

On at 10:30 AM during record review shows Resident #1(Date of Birth (DOB)) was admitted to facility on / . His records shows the " Right to Choose Your Health Care Provider ", informed consent for medications signed on / . The file contains the Bill of Rights and the Admission, Retention and Discharge Policy. There is documentation between resident or facility stating she would not return to the facility or that was given a discharged. Record review of the resident shows that he paid $721.00 for the month of , and . There was no documentation of a refund given and no documentation of resident being and sent to the hospital.

On at 10:30 AM during record review of admission and discharge log shows he was admitted - / and discharged on .

On at 11:52 AM during an interview with the administrator, she stated that she had not heard anything about Resident #1, according to administrator, she will be writing the check to the facility where Resident #1 is staying. The administrator, admitted that she had not given the refund to the resident or the facility were the residents is living now. Complainant was contacted and told me that she will be contacting the administrator to let her know how she could give the money pending to the facility were Resident #1 is staying.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Leo Alf
3666 Sw 5th Terrace
Miami, FL 33135

RE: CCR #2015004704

Dear Administrator:

This letter reports the findings of a Compliant Survey that was conducted on , 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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
XG90

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