

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/19/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966158	(X3) DATE SURVEY COMPLETED 08/03/2015
NAME OF PROVIDER OR SUPPLIER ADIUVO V	STREET ADDRESS, CITY, STATE, ZIP CODE 13232 SW 85 STREET MIAMI, FL 33183	

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

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on _____, 2015. Adiuvo V with Limited Nursing Services component had the following deficiency found at time of survey.

N277 LNS - Resident Care Standards

Based on record review and interview, the Assisted Living Facility failed to employ or contract with a nurse(s) who must be available to provide limited nursing services (LNS) as needed by residents.

Findings included:

Review of facility's record revealed that contract between Registered Nurse and Assisted Living Facility to provide limited nursing services was signed on ____/____/____.

In an interview with Registered Nurse was via telephone on _____ at 1:35 p.m. revealed that revealed that he finished contract with facility since _____ 2015.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Adiuvo V
13232 Sw 85 Street
Miami, FL 33183

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring 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

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