STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968205	R
NAME OF PROVIDER OR SUPPLIER **ALMAR ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2120 NW 18 TERRACE** **MIAMI, FL 33125**	

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

0000 Initial Comments

A Monitoring survey Re-Visit was conducted at Almar ALF Inc on . Almar ALF Inc with Limited Mental Health and Limited Nursing Services components had the following deficiencies found at the time of survey.

0127 Fiscal - Liability Insurance

Based on record review and interview the facility failed to maintain liability insurance coverage in force at all times.

Findings included:

On at 9:15 AM during the tour was observed the Liability Insurance was posted with the other licenses dated / expired / .

On at 12:00 PM interview with the administrator over the phone, she stated that she was aware that this document was missing because she was still working on it, and she was going to get it as soon as she could.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11968205

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
9/24/2015

Name of Facility
ALMAR ALF INC

Street Address, City, State, Zip Code
2120 NW 18 TERRACE
MIAMI, FL 33125

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 **A0055** Reg. # **58A-5.0185(6) 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 **AL241** Reg. # **58A-5.029(2) FAC** LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # 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**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Almar Alf Inc
2120 Nw 18 Terrace
Miami, FL 33125

Dear Administrator:

This letter reports the findings of a Monitoring Revisit Survey conducted on 24, 2015by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2015.

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

BBT7

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