STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964360	R
NAME OF PROVIDER OR SUPPLIER **BETHSHALOM ALF CORPORATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **7891 NW 171 STREET** **MIAMI, FL 33015**	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on . . . 29, 2015. Bethshalom ALF Corporation had uncorrected deficiencies at time of survey.

0010 Admissions - Continued Residency

Based on record review and interview the facility failed to have one out of the three (#2) sampled residents health assessment completed.
Findings included:
Reviewed Resident #2's health assessment. Resident #2's assessment was not completed in section B, it did not indicate yes or no if the resident needed assistance with self-administration of medications.
Interviewed the Owner on - at 9:45 AM, she confirmed the findings in regards to Resident #2's health assessment not being corrected at the time of the revisit survey.
Uncorrected Class III

AH Form Approved

State Form: Revisit Report

(Y1) **Provider / Supplier / CLIA / Identification Number**
AL11964360

(Y2) **Multiple Construction**
A. Building
B. Wing

(Y3) **Date of Revisit**

Name of Facility
BETHSHALOM ALF CORPORATION

Street Address, City, State, Zip Code
7891 NW 171 STREET
MIAMI, FL 33015

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 **A0162** Reg. # **58A-5.024(3) FAC** LSC	Correction Completed	ID Prefix **A0167** Reg. # **58A-5.025 FAC** LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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

, 2016

Administrator
Bethshalom Alf Corporation
7891 Nw 171 Street
Miami, FL 33015

Dear Administrator:

This letter reports the findings of a standard biennial revisit survey conducted on 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.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than . 11, 2016.**

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:ve
Enclosure

BBT7

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