STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964806	**03/14/2016**
NAME OF PROVIDER OR SUPPLIER **CASANOVA ALF #4**	STREET ADDRESS, CITY, STATE, ZIP CODE **1084 WEST 65 STREET** **HIALEAH, FL 33012**	

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

0000 Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on [redacted], 2016. Casanova ALF # 4 with Limited Nursing Services component had the following deficiency identified at the time of the survey:

0078 Staffing Standards - Staff

Based on record review and interview facility failed to provide evidence of a negative statement on an annual basis for Register Nurse contracted by facility to provide limited nursing services.

Findings included:

Record review of Register Nurse contracted by facility to provide limited nursing services revealed that the last [redacted] statement was dated [redacted].

Facility owner stated on / at 10:15 am that she sent the application to renew the facility license without Limited Nursing Services component, but that she will contact the nurse to get her new [redacted] statement.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Casanova Alf #4
1084 West 65 Street
Hialeah, FL 33012

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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 Sonia Bailey, Health Feacility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene [illegible]-Davis
Field Office Manager

AMD/sb
Enclosure
XG90

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