

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/07/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966672	(X3) DATE SURVEY COMPLETED 03/30/2016
NAME OF PROVIDER OR SUPPLIER LOURDES ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 14825 SW 82ST MIAMI, FL 33193	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on i. Lourdes ALF with a Standard license had the following deficiency found at the time of the survey:

0082 Training - /

Based on record review and interview the facility failed to provide documentation of providing an education course on and for one out of four sampled employees (Staff B).

Findings included:

On at 11:30 AM, record review revealed that Staff B () did not have documentation of the 2 hours training within 30 days of being hired.

On at 1:30 PM, the Administrator stated that she thought that she had all the documentation for this employee in the facility but she could not find it.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lourdes Alf
14825 Sw 82st
Miami, FL 33193

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 Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,


Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

XG90

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