STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967844	**03/31/2016**
NAME OF PROVIDER OR SUPPLIER **NOMEL'S ALF INC #2**	STREET ADDRESS, CITY, STATE, ZIP CODE **332 BISCAYNE LANE** **SEBASTIAN, FL 32958**	

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

0000 Initial Comments

An unannounced Biennial Abbreviated Licensure survey was conducted on 03/31/16 at Nomel's ALF Inc. The facility had a deficiency at the time of the visit.

0091 Training - Documentation & Monitoring

Based on record review and interviews, it was determined the facility failed to ensure all training(s) was documented on a certificate and placed in the employee files, for 2 of 2 sampled Employees (A and B).

The findings included:

Employee record review was conducted / with the Administrator present and revealed the following concerns.

1. There was no documentation showing Employee A, the Administrator (a Medication Technician), received required training related to Assistance with Self-Administration of Medications during the year 2015.

2. There was no documentation showing Employee B, a Medication Technician, received required training related to Assistance with Self-Administration of Medications during the year 2014.

This was discussed with and acknowledged by the Administrator on / at 10:50 AM. She stated they both received the training and she would obtain copies from the trainer. At the time of survey exit, no certificates were available.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Nomel's Alf Inc #2
332 Biscayne Lane
Sebastian, FL 32958

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at 561-381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dlt
Enclosure

XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com