

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965853	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/21/2016
NAME OF FACILITY BOSCH ALF, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3060 NW 19 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0077	Correction	ID Prefix A0078	Correction	ID Prefix AZ814	Correction
Reg. # 429.176 FS; 58A-5.019(1) FAC	Completed	Reg. # 58A-5.019(3) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed
LSC	04/21/2016	LSC	04/21/2016	LSC	04/21/2016
ID Prefix AZ815	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/21/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS) <i>[Signature]</i>	DATE 5/3/16	TITLE HFES	DATE 5/3/16

FOLLOWUP TO SURVEY COMPLETED ON 2/23/2016

☐ 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

May 3, 2016

Administrator
Bosch Alf, Inc
3060 Nw 19 Terrace
Miami, FL 33125

Dear Administrator:

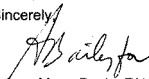
This letter reports the findings of a state licensure survey revisit conducted on April 21, 2016 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the 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

DT9D

