STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965853	06/08/2016
NAME OF PROVIDER OR SUPPLIER **BOSCH ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3060 NW 19 TERRACE** **MIAMI, FL 33125**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2016. Bosch ALF, Inc. (license # 10199) with Limited Mental Health component had the following deficiencies identified at the time of the survey:

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview the facility failed to provide proof that an employee took the initial 4 hours training in assistance with self-administration of medications for one out of 5 sampled employees (Staff E).

Findings included:

Personnel record review of Staff E revealed that she took a 2 hours of assistance with self-administration of medication training on / / . Also revealed that she was missing her initial 4 hours training.

The facility administrator stated on at 12:35 pm that Staff E also works for her in her other assisted living facility and that the original 4 hours training of assistance with self-administration of medication training must be there.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

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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