STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966278	**06/24/2016**
NAME OF PROVIDER OR SUPPLIER **OUR LADY OF LOURDES ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **14491 SW 153 TERRACE** **MIAMI, FL 33177**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on and concluded on . Our Lady Of Lourdes ALF, Inc with a Limited Mental Health Component, License #10517 had the following deficiency found at the time of the survey:

0162 Records - Resident

Based on record review and interview, the facility failed to ensure one out of five sampled residents (#5) to had a Power of Attorney (POA), Surrogate or Guardianship documentation in their charts.

Findings included:

On at 11:15 AM, record review found Resident #5's son signed her documents without a POA, Surrogate, or Guardianship documentation completed.

On at 1:00 PM during an interview with the Owner, he stated, he did not think the Power of Attorney was necessary because was her son the one who was signing, but he was going to request it as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Our Lady Of Lourdes Alf, Inc
14491 Sw 153 Terrace
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a Standard Biennial 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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