STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966967	07/05/2016
NAME OF PROVIDER OR SUPPLIER **NATALIA ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2118 SW151 PLACE** **MIAMI, FL 33185**	

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

0000 Initial Comments

A Complaint Survey (CCR#2016004612) was conducted on , 2016 and concluded on , 2016. Natalia ALF, Inc. (license # 11084) had deficiencies identified at the time of the survey.

0010 Admissions - Continued Residency

Based on record review and interview the facility failed to follow the continuing residency criteria for 1 out of 6 sampled residents (Resident #5).

Findings included:

Resident # 5 record review revealed that she was discharged from the facility to the hospital on and was in different hospitals and on rehabilitation until that she was discharged back to the assisted living facility. Also revealed that a health assessment was completed by her Primary Care Physician (PCP) on and stated that she had declined in her ability to ambulate for herself or with devices and that she was totally disoriented to complete the bathing activity. A new health assessment was completed by her PCP on after she came back to the facility and stated that resident #5 was not able to ambulate for herself and was mostly in her wheelchair; resident required total help for bathing, dressing, and toileting and assistance to transfer. Resident # 5 was referred to hospice by her PCP on .

The facility's Administrator stated on at 11:33 am: "Resident # 5 was sent to the hospital on because she was weak and her right leg was . She was mostly on the wheelchair and on the recliner. She was not able to ambulate for a while before being admitted to hospice. She used to rub her heels against each other when seated in the recliner."

On / the podiatrist that was performing care for Resident # 5 prior to the resident being sent to the hospital sent by fax a copy of the note from the last visit she did to Resident #5 on ; she specified that the resident was non ambulatory. Also stated that the resident had a in the right lateral malleoli that measured 1.3 cm x 1.2 cm and a new on the left heel that measured 1.4 cm x 1.5 cm.

Class III

0053 Medication - Administration

Based on observation, record review, and interview the facility failed to ensure that licensed personnel

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administered medications to 1 out of 6 sampled residents (Resident #4).

Findings included:

Record review of Resident #4's record revealed that she was admitted to the facility on and that she has been receiving hospice services since . Record review also revealed that her health assessment was completed on and stated that she requires assistance with all her activities of daily living and requires medication administration. The health assessment was missing the height and weight.

The facility administrator stated on at 1:00 pm that she would contact the primary physician for Resident #4 to have a new health assessment completed because unlicensed staff were giving medications to Resident #4.

Class III

0093 Food Service - Dietary Standards

Based on observation and interview the facility failed to have enough water in storage to be used during an emergency.

Findings included:

During tour of the facility on / at 9:25 am the surveyor observed in the patio shelves containing 12 containers with a capacity of 5 gallons each; 3 of the containers had water and the other 9 containers were empty. There were 6 residents admitted to the facility.

Last Ombudsman assessment was completed on and there was not enough emergency water at the time.

The facility's Administrator stated on / at 10:10 am: "I have a contract for the water and I am going to call them to replace the emergency water."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Natalia Alf Inc
2118 Sw151 Place
Miami, FL 33185
CCR #2016004612

Dear Administrator:

This letter reports the findings of a Complaint licensure survey that was concluded 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 Verlande Exil, Health Facility Evaluator Supervisor.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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