



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

September 29, 2016

Administrator
Florida Home Care Alf, Inc
2931 Nw 106 Street
Miami, FL 33147

Dear Administrator:

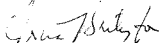
This letter reports the findings of a state licensure survey revisit conducted on September 12, 2016 by representative(s) of this office.

Attached is the provider's copy of the State Form, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967641	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/12/2016
NAME OF FACILITY FLORIDA HOME CARE ALF, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2931 NW 106 STREET MIAMI, FL 33147	

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 A0010	Correction	ID Prefix A0030	Correction	ID Prefix A0084	Correction
Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC	09/12/2016	LSC	09/12/2016	LSC	09/12/2016
ID Prefix AL243	Correction	ID Prefix AZ815	Correction	ID Prefix	Correction
Reg. # 429.075(1) FS; 58A-5.0191(8) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed
LSC	09/12/2016	LSC	09/12/2016	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)	DATE 9/29/16	TITLE HFS	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/30/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			