RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Hostal Nostalgia Alf
10670 Sw 7 Terrace
Miami, FL 33174

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

BBT7

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967407	R
NAME OF PROVIDER OR SUPPLIER **HOSTAL NOSTALGIA ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **10670 SW 7 TERRACE** **MIAMI, FL 33174**	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on 09/20/16. Hostal Nostalgia Alf with limited mental health and limited nursing services components and license number (11470) had the following deficiencies identified at the time of the survey:

0009 Admissions - Admission Package

Based on observation, record review and interview, the facility failed to have executed resident contract at the time of admission for one out of six (#6) sampled residents.
Findings included:
Observation on during facility tour at 11:47 AM showed Resident ' # 6 was seated at the dining table having lunch. During facility tour observed that Resident ' #6 occupied # at the facility.
Record review showed Resident #6's (admitted on) limited mental health resident Agreement for care was not signed or dated by Resident/ legal guardian or his representative party before or at the time of admission.
During an interview on At 12:50 AM Staff B (caregiver) acknowledged that Resident agreement for care need to be signed before or at the time of admission.
Class III

0055 Medication - Storage and Disposal

Based on observations and interview the facility failed to ensure that all medications are kept in a locked cart, other locked storage receptacle, or , at all times.
Findings included:
During the facility tour on at 11:47 Am an unlocked employee closet was observed containing unlabeled over-the-counter medications: Fish Oil 1000 mg and Centrum Silver (multi supplement).
During an interview on at 11:50 AM Staff B (caregiver) stated this medication was used by staff. She stated the closet did not have a lock.
Class III

L241 LMH - Records

Based on record review and interview, the Assisted Living Facility failed to ensure that one (Resident #6) out of six sampled residents had the mental health assessment and community living support plan within 30 days of admission.
Findings included:

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Review of Resident #6 ' s (admitted on) file revealed that health assessment (AHCA form 1823) dated , had diagnoses paranoia , and . Furthermore Resident #6 received ( ) $ 54.00 dollars. There was no documentation of a mental health assessment or a community support plan.
During an interview on at At 12:50 AM Staff B (caregiver) stated that she did not have the Community living support plan and agreement for Resident #6 ' . She stated it is very hard to receive this documentation.
Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967407 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSTAL NOSTALGIA ALF	10670 SW 7 TERRACE MIAMI, FL 33174

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 A0026	Correction	ID Prefix A0052	Correction	ID Prefix A0079	Correction
Reg. # 58A-5.0182(2) FAC	Completed	Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.019(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0084	Correction	ID Prefix A0092	Correction	ID Prefix A0093	Correction
Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.020(1) FAC	Completed	Reg. # 58A-5.020(2) FAC	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	
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 8/11/16	TITLE HFES	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/27/2016	☐ YES ☐ NO