



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Paula Perez Alf Inc
952 S W 136 Place
Miami, FL 33184

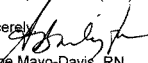
Dear Administrator:

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** , 2017. 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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**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/06/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967910	(X3) DATE SURVEY COMPLETED R 11/22/2016
NAME OF PROVIDER OR SUPPLIER PAULA PEREZ ALF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 952 S W 136 PLACE MIAMI, FL 33184	

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

0000 Initial Comments

A Standard Biennial revisit survey was conducted on 11-22-2016 at Paula Perez ALF Inc with Limited Mental Health service component, license number (11885.). There was a deficiency found at the time of the survey.

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe and clean environment for five of five residents (Residents # 1-5).

Findings:

Observation on 11-22-2016 at 11:00 in room (#2), ceiling area right corner observed a large black spot, rust and sagging plaster. On the wall over an empty resident bed which did not have a mattress there was an area of peeling paint. In the resident's room the wall near the ceiling observed an area of water damage and peeling plaster and paint. In the same room broken sliding doorway baselines.

Interviewed on 11-22-2016 at 12:00 PM, the Administrator confirmed the findings and stated that he has been demanding the owner to fix the broken sliding doorway, but it was not done.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967910	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
Y1	Y2	Y3
NAME OF FACILITY PAULA PEREZ ALF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 952 S W 136 PLACE MIAMI, FL 33184	

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 A0008	Correction	ID Prefix A0030	Correction	ID Prefix A0031	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.0182(7) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0093	Correction	ID Prefix A0160	Correction	ID Prefix AL243	Correction
Reg. # 58A-5.020(2) FAC	Completed	Reg. # 58A-5.024(1) FAC	Completed	Reg. # 429.075(1) FS; 58A-5.0191(8) 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	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON			☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		