STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968764	**12/21/2016**
NAME OF PROVIDER OR SUPPLIER **LA CASA ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **9318 MEMORIAL HWY** **TAMPA, FL 33615**	

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

0000 - Initial Comments

Assisted Living Facility

On / , a biennial relicensure survey was conducted at La Casa ALF. Deficient practice was identified at the time of the visit. The facility's license states 5 and it should be 6 residents.

(License # 12615)

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview the facility failed to ensure they provided ongoing activities program.

Findings included:

The surveyor observed an activity calendar with scheduled activities listed 2 hours a day six (6) days a week On / the residents did not have activities. A brief interview with residents revealed they did not do any of the activities listed on the calendar.
During an interview with staff C on / at 1:30pm it was stated the residents are encouraged to join activities but would rather watch television.
The Staff plans to speak to each resident and find new activities that would interest them

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
La Casa ALF
9318 Memorial Hwy
Tampa, FL 33615

Dear Administrator:

This letter reports the findings of a biennial 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the identified deficiency. 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 deficiency 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-basec 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr
Enclosure: State Form 5000-3547

XG90

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