

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967226	(X3) DATE SURVEY COMPLETED R 12/21/2016
NAME OF PROVIDER OR SUPPLIER ALF FAMILY SOLUTION CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 7235 SOUTH WATER WAY DRIVE MIAMI, FL 33155	

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

0000 - Initial Comments

A Standard Abbreviated Re-Visit survey was conducted on 12/21/16. ALF Family Solution Corp with Limited Mental Health Component, Lic#11312 had no deficiencies found at the time of the survey.



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

December 28, 2016

Administrator
Alf Family Solution Corp
7235 South Water Way Drive
Miami, FL 33155

Dear Administrator:

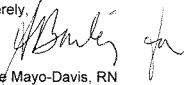
This letter reports the findings of a state licensure survey revisit conducted on December 21, 2016 by representative(s) of this office.

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

DT90



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967226	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/21/2016
NAME OF FACILITY ALF FAMILY SOLUTION CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 7235 SOUTH WATER WAY DRIVE MIAMI, FL 33155	

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 Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC LSC	Correction Completed 12/21/2016	ID Prefix A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed 12/21/2016	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed 12/21/2016
ID Prefix A0125 Reg. # 429.27(2) FS; 58A-5.021(3) FAC LSC	Correction Completed 12/21/2016	ID Prefix AL243 Reg. # 429.075(1) FS; 58A-5.0191(8) FAC LSC	Correction Completed 12/21/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS) <i>ES</i>	DATE 12/28/16	TITLE #LES	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/9/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO