STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969040	**12/14/2016**
NAME OF PROVIDER OR SUPPLIER **ALF BEIT SHALOM INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **9093 BANQUET WAY** **LAKE WORTH, FL 33467**	

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

0000 - Initial Comments

An unannounced Limited Nursing Services monitoring survey was conducted 12/14/16 ALF Beit Shalom, an Assisted Living Facility (license #12871). The facility had a deficiency identified at the time of the visit.

0190 - Administrative Enforcement - 58A-5.033(1-2) & (3)(b) FAC; 429.075(6)

On a survey was attempted at ALF Beit Shalom. There was no on present at the facility. A call was placed to the available business number. On at 9:55 AM, the Administrator confirmed that she was currently out of town and did not have anyone available to complete the survey. She also confirmed that there were no residents currently residing at the facility and they planned to remove the Limited Nursing Services specialty from their license.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Alf Beit Shalom Inc
9093 Banquet Way
Lake Worth, FL 33467

RE: Limited Nursing Services (LNS) Monitoring survey
Dear Administrator:

This letter reports the findings of a state monitoring licensure survey with LNS that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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