STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966962	08/13/2015
NAME OF PROVIDER OR SUPPLIER **ABUELITOS FELICES II ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **12744 SW 204 STREET** **MIAMI, FL 33177**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted at on , 2015. Abuelitos Felices II Alf Inc with Limited Mental Health component had the following deficiencies found at time of the survey:

L243 LMH - Training

Based on record review and interview, the facility failed to maintain documentation of having completed at least 3 hours training of Limited Mental Health continuing education for two out of three (Staff A and C) facility staff.

Findings include:

Review of Staff A, administrator and Staff C, caregiver records showed that they did not have documentation of having completed at least 3 hours training of Limited Mental Health continuing education. Staff A and C last training was dated / .

Interview conducted with Staff C, caregiver on / at 2:45 PM stated that she and the facility administrator had not taken a minimum of 3 hours training of Limited Mental Health continuing education.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Abuelitos Felices Ii Alf Inc
12744 Sw 204 Street
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a Standard Biennial Survey that was conducted on , 2015 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 , 2015.** 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Kristal Branton for

Arlene Mayo-Davie, RN
Field Office Manager

AMD:kb
Enclosure

XG90

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