Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965204	A. BUILDING: _____ B. WING _____	06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAFFA CORP	13961 SW 75 STREET MIAMI, FL 33183

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A COVID-19 control monitoring visit was conducted at Raffa Corp. on . A deficiency was identified at the time of the visit.	A 000		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all staff were trained in their duties and are responsible for implementing the emergency management plan. Staff A and B was unable to start the alternate power source (portable generator). Findings Included: On 21 at 9:45 AM observed a portable generator; Wen Model 56475 4750 WATTS. Staff A and B was asked to turn on the generator. On 21 at 9:45 AM Staff B stated, "We have never turned on the generator, the administrator is the one that runs it at least twice a week. I will ask her to teach us how to run the generator." Class III	A 182		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE