STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953319	03/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
My Home Alf, Inc	290 Nw 188th Street Miami, FL 33169	

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

Revisit Corrected Tags:
0008-Admissions - Health Assessment-03/06/2014
0025-Resident Care - Supervision-03/06/2014
0026-Resident Care - Social & Leisure Activities-03/06/2014
0053-Medication - Administration-03/06/2014
0054-Medication - Records-
0056-Medication - Labeling And Orders-
0074-Staffing Standards - Personnel File (bgs)-
0078-Staffing Standards - Staff-
0079-Staffing Standards - Levels-
0090-Training -
0093-Food Service - Dietary Standards-
0126-Fiscal - Resident Accounting-
0162-Records - Resident-
0165-Risk Mgmt & Qa; Adverse Incident Report-

Revisit Repeat Tags:
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs

Revisit New Tags:

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Survey was completed at My Home ALF, Inc on 03-06-14. There were deficiencies identified during this survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on record review and interview facility failed to have a signed consent form in her file for review during the follow up survey.

Findings includes:
Observation reveals resident #4, had 1/2 bed rails on her bed. Record review coonclued there was a phsycial order for the use of half rails dated . Further review revealed there is no consent for the use of those half rails from the resident or resident's representative.

Interview with the administrator on at 9:15 am, he stated that she (resident) did not have one and did not know she needed one to be signed and dated by the resident.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
My Home Alf, Inc
290 Nw 188th Street
Miami, FL 33169

Dear Administrator:

This letter reports the findings of a revisit survey to a biennial conducted on , 2014by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2014.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

BBT7

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