

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967473	(X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER Maria's Alf	STREET ADDRESS, CITY, STATE, ZIP CODE 3211 W Sitka Street Tampa, FL 33614	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
 St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
 St - A - 0081 - 58a-5.019(2) Fac - Training - Staff In-Service S-S= D
 St - A - 0090 - 58a-5.019(11) Fac - Training - - - - - S-S= D

Specific Tag Findings:

Assisted Living Facility

An abbreviated biennial licensure survey with limited mental health (LMH) services was conducted on

The Maria's Assisted Living Facility had deficiencies found at the time of the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have a personnel file which contained a free from communicable statement including signed by a health care provider for one (#C) of four direct care staff sampled for free from communicable statements including

Findings Include:

Record review of staff #C's personnel file on revealed there was no free from communicable statements including signed by a health care provider. Staff #C had been hired on and he had thirty days to acquire both the free from communicable statement and a examination.

When interviewed on at 2:15 p.m., the administrator verified the required documentation of a communicable statement and the examination for staff #C was not in his personnel file.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2014

Administrator
Maria's Alf
3211 W Sitka Street
Tampa, FL 33614

Dear Administrator:

This letter reports the findings of a abbreviated biennial state licensure survey that was conducted on _____, 2014 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. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 **Paul Brown**, HFES, at (727)552-2000.

Sincerely,

for

Patricia Reid Cauffman
Field Office Manager

PRC/clt

Enclosure: State (5000-3547) Form

