| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965060 | 03/10/2015 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| ALEA ASSISTED LIVING FACILITY | 5304 NW 16TH STREET LAUDERHILL, FL 33313 | |

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

**0000 - Initial Comments**

An unannounced licensure survey was conducted on [redacted] at Alea Assisted Living Facility. The facility had no deficiencies found at the time of the visit.

**0079 - Staffing Standards - Levels - 58A-5.019(3) FAC**

Based on record review and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

The findings include:

A request was made to the facility owner on [redacted] at 9:15 AM for the facility's current month staffing schedule. During an interview with the Owner, at this time, she stated the facility does not have a written worked schedule. The Owner was not able to provide any documentation indicating the facility's staffing pattern for the employees currently working at the facility for a census of 7 residents. Therefore, it could not determined what days and hours each staff member works. During a telephone interview at 11:35 AM on [redacted] with the facility's Administrator, she stated she was not aware they were required to have a written staffing schedule.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Alea Assisted Living Facility
5304 NW 16th Street
Lauderhill, FL 33313

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on ..... 10, 2015 by representative from 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 after ..... 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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