STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966984	R
NAME OF PROVIDER OR SUPPLIER **MAYLE ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **19768 BEL-AIRE DRIVE** **CUTLER BAY, FL 33157**	

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

0000 Initial Comments

A Complaint (CCR #2015002861 and 2015002928) survey revisit was conducted on . Mayle ALF, Inc. with Limited Mental Health component had the following deficiencies at the time of the survey:

0077 Staffing Standards - Administrators

Based on record review and interview, the Assisted Living Facility still failed to ensure that the Manager met the same qualifications of the Administrator, the facility to have the Manager proof of high school diploma or G.E.D.

Findings as follow:

Record review on showed the facility's Administrator (hired /) supervised two facilities. The facility failed to have documentation of the high school diploma or its equivalent for the appointed Manager.

Phone interview on at noon, the Manager stated that he had a high school diploma but not in facility available for review.

Uncorrected Class III

0079 Staffing Standards - Levels

Based on observation, record review, and interview, the Assisted Living Facility failed to maintain the minimum staffing hours per week. The facility also failed to follow its staffing pattern.

Findings as follow:

On at 6:50 a.m. observed Staff D alone in the facility caring for 6 residents and a day care participant. Further observations on at 10:00 a.m. found Staff D still alone caring for residents, Staff C did not show up as documented on the schedule.

Staffing schedule review showed Staff C and Staff D were scheduled to work at the facility on from 7 am to 7 pm.

On at 7::00 a.m. Staff D stated Staff C did not come to work because had her son sick.

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

Phone interview on at 10:00 a.m., the Manager stated that Staff C could not come to work because she had no a ride to be transported to facility. The manager stated that was going to pick up Staff C that lived far from facility.

Uncorrected Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11966984	A. Building B. Wing	7/24/2015

Name of Facility	Street Address, City, State, Zip Code
MAYLE ALF, INC	19768 BEL-AIRE DRIVE CUTLER BAY, FL 33157

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0030** Reg. # **58A-5.0182(6) FAC; 429.28** LSC		ID Prefix **A0054** Reg. # **58A-5.0185(5) FAC** LSC		ID Prefix **A0078** Reg. # **58A-5.019(2) FAC** LSC	
ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC		ID Prefix **A0120** Reg. # **429.17(3) FS; 429.275(1)58** LSC		ID Prefix **A0161** Reg. # **429.275(2) FS; 58A-5.024(2** LSC	
ID Prefix **A0181** Reg. # **58A-5.026(2) FAC** LSC		ID Prefix **AL243** Reg. # **429.075(1) FS; 58A-5.0191(** LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:** 7/31/15	**Signature of Surveyor:**	**Date:**	
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**	

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

31, 2015

Administrator
Mayle Alf, Inc
19768 Bel-Aire Drive
Cutler Bay, FL 33157

Dear Administrator:

This letter reports the findings of a Complaint revisit survey conducted on , 2015by 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.

All deficiencies shall be corrected no later than , 2015.

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, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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