STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965488	08/10/2015
NAME OF PROVIDER OR SUPPLIER **PARKLAKE SENIOR PALACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4229 SW 157 COURT** **MIAMI, FL 33185**	

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

0000 Initial Comments

A Complaint (CCR# 2015007358) Survey was conducted on . Parklake Senior Palace had deficiencies at the time of the survey.

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to obtain a statement from a health care provider for one out of four (Staff D) staff as evidence to show freedom from any signs or symptoms of a communicable including .

Findings included:

Personnel record review was conducted on at 10:30 AM showed Staff D did not have documentation from a health care provider that showed she did not have any signs or symptoms of a communicable including . Staff D was hired on .

Interview on at 2:00 PM, the facility's Administrator acknowledged that there was no documentation from a health care provider that Staff D did not have any signs or symptoms of a communicable including .

Class III

0161 Records - Staff

Based on record review and interview the facility failed to provide documentation of compliance with level 2 background screening for one out of four (Staff D) sampled staff.

Findings included:

Review of Staff D's personnel record on showed it did not contain documentation of compliance with level 2 background screening.

Interview on at 12:00 PM, the Administrator acknowledged that Staff D did not have documentation of compliance with level 2 background screening at the facility.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Parklake Senior Palace
4229 Sw 157 Court
Miami, FL 33185

RE: CCR #2015007358

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2015 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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