AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968761	11/12/2015
NAME OF PROVIDER OR SUPPLIER **MOORE CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1397 WEST 35TH STREET** **WEST PALM BEACH, FL 33404**	

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

0000 Initial Comments

An unannounced limited nursing services monitoring survey was conducted on I/ at Moore Care ALF. The facility had a deficiency at the time of the visit.

Z816 Background Screening-Compliance Attestation

Based on interviews and record review, it was determined that the facility failed to ensure that all employees met the criteria for compliance with background screening requirements prior to allowing employees to provide care to facility residents . The facility did not obtain a new background screening for an employee with an employment lapse of more than 90 days, for 1 of 2 employee records reviewed.

The findings included:

During a limited nursing services monitoring visit on I/ , the surveyor noted that Staff #B ' s level II background screening was completed as of .

Staff #B ' s employment application contained only the year(s) in which Staff #B had worked at previous employers. There were no months or dates given, making it unclear as to whether there had been lapses in employment between Staff #B ' s previous jobs. There was also no date on the application to indicate the date the application was completed or the date of hire. Photographic evidence was obtained.

During a 3:20 PM interview with the Administrator, the Administrator stated that Staff #B ' s date of hire was I/ .

During a 2:00 PM telephone interview on I/ , Staff #B stated that she had left employment with another facility in , 2014 and had begun working at a nurse registry in , 2014. The surveyor asked Staff #B if she was employed in health care during the employment lapse from , 2014 until , 2014. Staff #B stated that she was not.

During subsequent I/ / telephone interviews with Staff #B ' s previous employers, the surveyor confirmed that Staff #B ' s last day at the previous facility was I, 2014 and that Staff #B did not begin working at the nurse registry until I, 2014. There was no evidence of the Administrator having verified the dates of previous employment for Staff #B was provided to the surveyor.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968761	**11/12/2015**
NAME OF PROVIDER OR SUPPLIER **MOORE CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1397 WEST 35TH STREET** **WEST PALM BEACH, FL 33404**	

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

A review of the facility ' , 2015 through ; 2015 staffing schedules revealed that Staff #B has regularly worked the 7 PM to 7 AM shift at the facility during each of the months reviewed. Photographic evidence was obtained.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Moore Care ALF
1397 West 35th Street
West Palm Beach, FL 33404

RE: Monitoring Survey

Dear Administrator:

This letter reports the findings of a monitoring survey that was conducted on , 2015 by a representative 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com