STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963986	R
NAME OF PROVIDER OR SUPPLIER **HIALEAH ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **158 WEST 8 STREET** **HIALEAH, FL 33010**	

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

0000 Initial Comments

Complaint (CCR #2015006226, CCR #2015006089, and CCR # 2015007005) survey revisit was conducted on , 2015. Hialeah ALF with Limited Mental Health component had the following deficiencies found at time of survey:

0078 Staffing Standards - Staff

Based on record review and interview the facility failed to provide evidence of a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for one out of seven (F) sampled staff.

Findings included:

On at 11:00 AM record review found Staff F (hired) did not have evidence of a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable within 30 days of employment.

On at 3:30 PM during an interview with Assistant Administrator acknowledged the facility did not have the documentation after reviewing personnel files.

Uncorrected Class III

0093 Food Service - Dietary Standards

Based on observations, record review, and interview the facility failed have a 3 day supply of nonperishable food for a census of sixteen residents. The facility also failed to show that a licensed dietitian reviewed the menu.

Findings included:

Tour conducted on at 9:30 AM found one can of powdered milk with 97 ounces available for the emergency food supply. The facility is required to have on hand 768 ounces of milk for a census of 16 residents.

Record review found the facility's dietician's license on file had expired on . The facility did not have documentation of the current license.

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

On at 2:00 PM the Assistant Administrator acknowledged the current dietician's license was not available and the that the facility has one can of milk.

Uncorrected Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11963986

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
10/28/2015

Name of Facility
HIALEAH ALF INC

Street Address, City, State, Zip Code
158 WEST 8 STREET
HIALEAH, FL 33010

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 **A0079** Reg. # **58A-5.019(3) FAC** LSC		ID Prefix **A0152** Reg. # **58A-5.023(3) FAC** LSC		ID Prefix **A0165** Reg. # **429.23(1-4 & 6-10) FS; 58A** 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		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** [signature]	**Date:** 12/8/15	**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

, 2015

Administrator
Hialeah Alf Inc
158 West 8 Street
Hialeah, FL 33010

Dear Administrator:

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

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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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