

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 12/29/2015
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966629	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SHALON ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 7046 S W 103 PLACE MIAMI, FL 33173	

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

0000 Initial Comments

An Abbreviated Biennial Survey was conducted on . Shalon ALF had the following deficiency found at time of the survey:

Z816 Background Screening-Compliance Attestation

Based on record review and interview the facility failed to have 1 out of 4 (Staff B) facility staff background screened every 5 years.

Findings as follow:

Record review showed the facility failed to have the background screening performed every 5 years for Staff B. Record review found the background screening for Staff B was dated .

On at 11:00 a.m. the facility's Administrator stated they had to do a new background screening for Staff B.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Shalon Alf
7046 S W 103 Place
Miami, FL 33173

Dear Administrator:

This letter reports the findings of an abbreviated biennial licensure 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 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 , 2016.** 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

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