STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910988	01/05/2016
NAME OF PROVIDER OR SUPPLIER **APOSTALADO HOME #3, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13510 SW 79 STREET** **MIAMI, FL 33183**	

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

0000 Initial Comments

A Standard Biennial survey was conducted on . I/ . Apostalado Home #3, Inc had deficiencies found at the time of the survey.

0161 Records - Staff

Based on observation, record review, and interview the facility failed to provide a copy of the employment application with references for one out of four (Staff C) sampled staff.

Findings included:

Observation made during the course of the survey on I/ revealed that Staff C was providing personal services to residents.

Review of Staff C's personnel record on I/ showed it did not contain a copy of the employment application with references.

Interview conducted on I/ at 10:10 AM, Staff C stated that she has been working in the facility for two weeks.

Interview conducted on I/ / at 2:00 PM, the facility's Administrator stated that Staff C did not have an employment application with references in her file.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Apostalado Home #3, Inc
13510 Sw 79 Street
Miami, FL 33183

Dear Administrator:

This letter reports the findings of a standard biennial licensure survey that was conducted on , 2016 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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