

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/20/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964602	(X3) DATE SURVEY COMPLETED 01/07/2016
NAME OF PROVIDER OR SUPPLIER CASITA ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 13562 SW 38 LANE MIAMI, FL 33175	

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

0000 Initial Comments

An extended congregate care monitoring survey was conducted on , 2016. Casita Alf with Extended Congregate Care and Limited Mental Health components had the following deficiency identified at the time of survey:

Z815 Background Screening: Prohibited Offenses

Based on record review and interview, Assisted Living Facility failed to rescreened one of six (Caregiver B) sampled staff by , 2015.

Findings included:

Record review of Caregiver B's personnel file revealed the last background screening was dated .

Review of background screening website on // revealed that Caregiver B's background screening showed "screening in progress."

In an interview on // at 2:41 PM the Administrator revealed that she was not aware that regulation changed about the new background screening.

Unclassified Deficiency



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Casita Alf
13562 Sw 38 Lane
Miami, FL 33175

Dear Administrator:

This letter reports the findings of an extended congregate care monitoring state 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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