STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966629	R 02/18/2016
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 revisit was conducted on . Shalon ALF had deficiencies found at time of the survey.

0083 Trainina - First Aid and

Based on observations, record review, and interview, the facility failed to ensure that at least one staff member who is trained in and First Aid is in the facility at all times when the residents are in the facility. This was evident for Staff E.

Findings include:

Observations on / at 9:30 AM found Staff E was in care of the residents and providing personal services to them.

Record review and request for Staff E on showed that no record was available in the facility for this staff.

Interview conducted on at 11:00 AM, Staff E stated "I only work at the facility sometimes. I have been working in another facility owned by the same owner for a long time."

Interview conducted on / at 2:45 PM, Staff F stated "Staff E had the and First Aid training but her record was not at the facility during the survey."

Class III

Z814 Backaround Screenina Clearinahouse

Based on observations and record review, the facility failed to register the employees in the clearinghouse for five out of five (Staff A, B, C, D and E) sampled staff.

Findings include:

Observations on at 9:30 AM found Staff E was in care of the residents and providing personal services to them.

Staff schedule review showed Staff A, B, C, and D were scheduled to work at the facility.

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	AL11966629	R
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)

Background screening review showed that the facility did not register any employees in the clearing house database.
Interview conducted on at 11:00 AM, Staff E stated "I only work at the facility sometimes. I have been working in another facility owned by the same owner for a long time."

Unclassified

Z815 Backaround Screenina: Prohibited Offenses

Based on observations, record review, and interview, the facility failed to provide evidence of Level II background screening for one out five (Staff E) sampled staff.

Findings include:

Observation on at 9:30 AM found Staff E was in care of the residents and providing personal services to them.

Interview conducted on / at 11:00 AM, Staff E stated "I only work at the facility sometimes. I have been working in another facility owned by the same owner for a long time."

Record review found the facility did not have a level II background screening for Staff E. The background screening database was reviewed during the survey, it showed there was no evidence of the level II background screening completed for Staff E.

Interview conducted on / / at 11:15 AM, Staff F stated "Staff E had Level II background screening but her record was not at the facility during the survey."

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966629 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALON ALF	7046 S W 103 PLACE MIAMI, FL 33173

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix AZ816 Reg. # 408.809(2)(a-c) FS LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** JJ	**DATE** 3/3/14	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/3/2015	☐ 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

, 2016

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

Dear Administrator:

This letter reports the findings of an abbreviated biennial revisit survey conducted on 18, 2016 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** .

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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