

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 03/11/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965359	(X3) DATE SURVEY COMPLETED R 03/07/2016
NAME OF PROVIDER OR SUPPLIER YESENIA ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 15608 SW 63 TERRACE MIAMI, FL 33193	

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

0000 Initial Comments

A Standard Biennial 2nd revisit survey was conducted on - and concluded on - at Yesenia ALF. The facility had an uncorrected deficiency at the time of survey.

0079 Staffing Standards - Levels

Based on observation, record review, and interview the facility failed to maintain a written work schedule which reflects its staffing pattern for a given time period.

Findings included:

Arrived to the facility on - at 11:05 AM, found Staff B (Administrator) alone with five residents.

Record review on - showed the facility's staffing pattern had Staff A and B working from 7:00 Am to 7:00 PM.

Interviewed the Administrator on - at 9:30 AM in regards to the facility's failure to have two Employees (A/B) working on -. The Administrator stated that Employee A was at the doctor's office during the morning of the survey and returned to the facility around 1:30 PM after the surveyor had left the facility.

UNCORRECTED

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965359	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
NAME OF FACILITY YESENIA ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 15608 SW 63 TERRACE MIAMI, FL 33193	

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 A0030	Correction	ID Prefix A0083	Correction	ID Prefix A0161	Correction
Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ815	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>ce</i>	DATE 3/11/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/12/2015		☐ 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

1, 2016

Administrator
Yesenia Alf
15608 Sw 63 Terrace
Miami, FL 33193

Dear Administrator:

This letter reports the findings of a **second** Standard Biennial Licensure Revisit Survey concluded on 7, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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 11, 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(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

YOSF

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