AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967152	03/11/2016
NAME OF PROVIDER OR SUPPLIER **MAGALY VALDESPINO ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **3204 WEST LEROY STREET** **TAMPA, FL 33607**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On [redacted], 2016, an abbreviated biennial relicensure survey with limited mental health (LMH) services was conducted at Magaly Valdespino assisted living facility. Deficient practice was identified during the surveys.

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to have in staff personnel files written statements from health care providers documenting that the direct care staff does not have any signs or symptoms of communicable [redacted] for two (#B & #C) of three direct care staff who were sampled for communicable [redacted].

Findings included:

Record review of staff #B's personnel file on [redacted] revealed staff #B was hired on [redacted] and there was no statement from a health care provider which stated staff #B was free of any signs or symptoms of communicable [redacted].

Record review of staff #C's personnel file on [redacted] revealed staff #C was hired on [redacted] and there was no statement from a health care provider which stated staff #B was free of any signs or symptoms of communicable [redacted].

When interviewed on [redacted] at 1:30 pm, the administrator verified the communicable [redacted] statement was not in staff #B and #C's personnel files.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Magaly Valdespino ALF
3204 West Leroy Street
Tampa, FL 33607

Dear Administrator:

This letter reports the findings of a abbreviated biennial state licensure survey with limited mental health (LMH) 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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