STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967529	03/03/2016
NAME OF PROVIDER OR SUPPLIER **ADELA'S GARDENS ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **12732 SW 93 STREET** **MIAMI, FL 33186**	

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

0000 Initial Comments

A Change of Ownership survey was conducted on , 2016. Adela's Gardens ALF Inc had the following deficiencies found at time of the survey:

Z814 Background Screening Clearinghouse

Based on observation, record review and interview, the facility failed to register the employees in the Background Screening Clearinghouse for four out of four sampled staff (Staff A, B, C, and D).

Findings Include:

Observation on at 9:30 AM showed Staff C and D were in care of the residents and providing personal services to them.

Staff schedule review showed that Staff A, B, C and D were scheduled to work at the facility.
Clearinghouse review showed that the facility did not register any employee.
On at 2:30 PM, Staff A, th Administrator stated that he did not register any employee in the clearinghouse.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Adela's Gardens Alf Inc
12732 Sw 93 Street
Miami, FL 33186

Dear Administrator:

This letter reports the findings of a Change of Ownership 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
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