STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967229	03/03/2016
NAME OF PROVIDER OR SUPPLIER **PLAMAR HOME CARE SERVICES**	STREET ADDRESS, CITY, STATE, ZIP CODE **4407 S W 162 PLACE** **MIAMI, FL 33185**	

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

0000 Initial Comments

An Abbreviated Biennial Survey was conducted on . Plamar Home Care Services had the following deficiencies at the time of the survey:

Z814 Backaround Screenina Clearinahouse

Based on observation, record review, and interview the facility failed to register with the clearinghouse (background screening website) and maintain the employment status for 5 out of 5 facility employees (Staff A, B, C, D and E).

Findings as follow:

On at 8:53 a.m. Staff C and D were observed working in facility. On at 9:05 a.m. Staff B arrived to facility.

Review of the staffing schedule documented the facility had five staff members (A, B, C, D, and E)

Review of the background screening website for providers, documented, the facility had no employees registered at the mentioned site.

On at 12:39 p.m. the facility's owner stated "I did not know the facility needed to register the facility employees in the background screening website."

Unclassified

Z815 Backaround Screenina: Prohibited Offenses

Based on observations, record review, and interview the facility failed to have one out of five (Staff C) rescreened by , 2015.

Findings as follow:

On at 8:53 a.m. Staff C was observed working in facility.

Record review Staff C's last level 2 background screening was dated / .

On at 10:15 a.m. Staff C stated "I have been working in this facility for 6 years."

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Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Plamar Home Care Services
4407 S W 162 Place
Miami, FL 33185

Dear Administrator:

This letter reports the findings of an abbreviated biennial 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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