STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966606	03/16/2016
NAME OF PROVIDER OR SUPPLIER **PARAH INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **701 SW TULIP BLVD** **FORT PIERCE, FL 34953**	

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

0000 Initial Comments

An unannounced biennial relicensure survey was conducted at Parah Inc, on / . Parah Inc. had a deficiency found at the time of the visit.

0078 Staffing Standards - Staff

Based on record review and interview, it was determined the facility failed to ensure that all direct care staff members had documentation from a healthcare provider indicating freedom of ( ) annually, for 3 out of 3 sampled staff files reviewed (Staff A, B and C).

The findings included:

Record review of personnel files for Staff A, B and C revealed no evidence or documentation from a healthcare provider indicating freedom of for 2015 or 2016. During an interview with the Administrator on at 11 AM, it was revealed the facility didn't have documentation indicating freedom of for Staff A, B and C. The Administrator stated, that she was aware that none of the staff had been tested in the past year and that the facility was out of compliance.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Parah Inc.
701 SW Tulip Blvd
Fort Pierce, FL 34953

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb
Enclosure : AHCA Form 5000-3547

XG90

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