

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 04/25/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968240	(X3) DATE SURVEY COMPLETED 04/05/2016
NAME OF PROVIDER OR SUPPLIER BLESSING ALF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 NE 154 TERRACE MIAMI, FL 33162	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2016. Blessing ALF LLC had the following deficiencies identified at time of survey.

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to ensure qualified staff submitted a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The facility also failed to maintain documentation of a negative examination documented on an annual basis for two out of six (#C and E) sampled staff.

Findings included:

Record review on found that Staff C and Staff E did not have a written statement documenting signs and symptoms of communicable and proof of a negative examination documented on an annual basis. The last statement for Staff C was dated and expired on / ; Staff C was dated to ;

Interview on at 4:50 PM with the Administrator acknowledge the staff did not have an updated proof of negative in file.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 14, 2016

Administrator
Blessing Alf Lic
1051 Ne 154 Terrace
Miami, FL 33162

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on January 14, 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 January 14, 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

XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone: (305) 593-3100; Fax: (305) 593-3121
AHCA.MyFlorida.com



Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida