

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 04/19/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966629	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER SHALON ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 7046 S W 103 PLACE MIAMI, FL 33173	

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

0000 Initial Comments

An Abbreviated Biennial Survey 2nd revisit was conducted on . Shalon ALF had deficiencies found at time of the survey.

0079 Staffing Standards - Levels

Based on observation and record review the facility failed to ensure that the staffing pattern was followed.

Findings as follow:

Arrived to the facility on 11:55 a.m. and found Staff C alone in the facility caring for a census of five residents alone.

Record review showed the facility's staffing pattern had two staff members scheduled to work from 7 a.m. to 7 p.m.

Class III

Z814 Backaround Screenina Clearinahouse

Based on observation, record review, and interview the facility failed to register and maintain 4 of 4 (A-D) facility staff in the background screening's clearinghouse.

Findings as follow:

On at 11:55 a.m. observed Staff C alone in the facility assisting residents with lunch.

The facility's staffing patten showed Staff A, B, C, and D were scheduled to work.

The background screening clearinghouse review on at 12:10 a.m. showed the facility did not have any employees registered on their employee roster.

On at 12:20 a.m. Staff C was informed and acknowledged the facility did not have any staff registered in the clearinghouse.

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11966629	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
NAME OF FACILITY SHALON ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 7046 S W 103 PLACE MIAMI, FL 33173	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0083	Correction	ID Prefix AZ815	Correction	ID Prefix	Correction
Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	☐	REVIEWED BY (INITIALS)	DATE 4/19/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/3/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 1, 2016

Administrator
Shalon Alf
7046 S W 103 Place
Miami, FL 33173

Dear Administrator:

This letter reports the findings of a **second** Biennial Licensure Revisit Survey conducted on July 7, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than July 1, 2016.**

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

YOSF

