| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964407 | 04/28/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**CASA LLANES ALF, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**5861 E 4TH AVENUE**<br>**HIALEAH, FL 33013** | |

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

**0000 Initial Comments**

A Standard Biennial Survey was conducted on , 2016. Casa Llanes ALF, Inc. with Limited Nursing Services component had deficiencies identified at the time of the survey:

**0077 Staffing Standards - Administrators**

Based on record review and interview the facility failed to show documentation that the manager completed high school or G.E.D.

Findings included:

Record review of the manager employee record revealed that there was no G.E.D or high school diploma available for review.

Caregiver D stated on at 11:00 am that the manager completed her high school in Cuba but that he is not sure if she will be able to get a copy from Cuba to provide it to the facility.

Class III

**0078 Staffing Standards - Staff**

Based on record review and interview the facility failed to maintain, within 30 days of the beginning of employment, a written statement from a health care provider documenting that the manager does not have any signs or symptoms of communicable for one of five sampled employees (Staff D). The facility also failed to provide documentation of a negative examination.

Findings included:

Record review of the facility manager revealed that there was no written statement from a health care provider documenting that the manager does not have any signs or symptoms of communicable and no evidence of a negative examination.

Staff D stated on at 11:05 am that he knew that the manager was missing the physical examination and the test and that he would make sure that she has it done as soon as possible.

Class III

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11964407** | **04/28/2016** |
| NAME OF PROVIDER OR SUPPLIER **CASA LLANES ALF, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE **5861 E 4TH AVENUE HIALEAH, FL 33013** | |

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

**0181 Emergency Plan Approval**

Based on record review and interview the facility failed to provide documentation of submitting an annual emergency plan for approval.

Findings included:

Record review revealed that the emergency plan available for review at the facility was approved on [redacted].

On [redacted] at 9:10 am Caregiver D stated: "I send the emergency plan by email to the person that has to aprove it not by regular mail and he has not sent me the approval back to me. I called him yesterday and left him a message, but he has not called me back."

Class III

**Z814 Background Screening Clearinghouse**

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

Findings as follow:

Review of the staffing schedule documented the facility had 5 staff members (Staff A, B, C, D and E).

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

Caregiver D stated on [redacted] at 11:10 am that the facility consultant set up a user name and a password for him to update the roster but it was not working and that he would attempt to update the roster as soon as possible.

Unclassified.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Casa Llanes Alf, Inc
5861 E 4th Avenue
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a Standard Biennial 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
XG90

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