STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967287	**04/25/2016**
NAME OF PROVIDER OR SUPPLIER **FAMILY FIRST ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **15600 SW 143 AVENUE** **MIAMI, FL 33177**	

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

0000 Initial Comments

A Standard Biennial Survey was made on . Family First ALF inc. has the following deficiency at the time of the visit:

0079 Staffing Standards - Levels

Based on observation, record review and interview the facility failed to failed to maintain an accurate staff schedule.

Findings:

On at 8:40 a.m. Staff D and E were observed providing assistance to 4 residents. At 10:15 a.m., Staff E was observed assisting resident # 2 to wake up and get up from a chair in the living . At 10:50 a.m. Staff D was observed assisting with lunch preparation.

A review of the Staff Schedule for showed Staff D was scheduled to work from 7 am to 7 pm, however Staff E was not on the schedule.

On at 11:55 a.m. the facility administrator stated Staff E had not yet been added to the staff schedule.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Family First Alf, Inc
15600 Sw 143 Avenue
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a 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

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