STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965827	R 05/31/2016
NAME OF PROVIDER OR SUPPLIER **ALF SEVILLA HOME CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **10844 SW 154 TERRACE** **MIAMI, FL 33157**	

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

0000 Initial Comments

A Standard Biennial Survey 2nd revisit was conducted on / . ALF Sevilla Home Care Corp. (License Number: 10152) with Limited Mental Health component had the following deficiencies found at the time of the survey:

0079 Staffing Standards - Levels

Based on observation, record review and interview the facility failed to have an accurate Staffing schedule which included the minimum staffing to provide resident supervision and to meet residents' needs.

Findings as follow:

On / at 9:50 a.m. it was observed Staff B (owner/caretaker) in facility, alone,with a Census of 6 residents.

Review of the Staffing schedule showed Staff B and Staff C were scheduled to work from 8 am to 8 pm.

On / at 9:55 a.m. Staff B stated, Staff C was not in the facility due to went to a Doctor's appointment.

Class III

Z814 Background Screening Clearinghouse

Based on record review and interview the facility failed to register 2 of 3 (Staff A and C) facility Staff in the Background Screening Clearinghouse database.

Findings:

Record review showed the following Staffing Schedule:

Staff A working from 8 PM to 8 AM
Staff B working from 8 am to 8 PM
Staff C working from 8 am to 8 PM

Review of the Background Clearinghouse database showed that only Staff C was registered on the

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facility's roster.

On / at 10:15 a.m. Staff B stated she believed the Administrator had registered all Staff on the Clearinghouse Database.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Alf Sevilla Home Care Corp
10844 Sw 154 Terrace
Miami, FL 33157

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

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