

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/05/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966704	(X3) DATE SURVEY COMPLETED 06/24/2016
NAME OF PROVIDER OR SUPPLIER KELLEY ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 10410 SW 127TH AVENUE MIAMI, FL 33186	

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

0000 Initial Comments

An Abbreviated Biennial survey was conducted on [redacted], Kelley ALF Inc with Limited Mental Health component, license number 10880, had deficiencies found at the time of the survey.

0162 Records - Resident

Based on record review and interview, the facility failed to maintain documentation in the resident's record regarding appointment of a health care surrogate, guardian or power of attorney for 1 out of 4 sampled residents (Resident #4).

Findings included:

Record review on [redacted] showed that Resident's #4 daughter signed her documents; however, there was no documentation in her record to show that the resident had appointed a health care surrogate, guardian, or power of attorney to represent her and sign her paperwork.

Interview conducted on [redacted] at 1:00 PM, Staff B, caregiver stated that the facility did not have documentation that Resident #4 had appointed a health care surrogate, guardian, or power of attorney to represent her and sign her paperwork.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Kelley Alf
10410 Sw 127th Avenue
Miami, FL 33186

Dear Administrator:

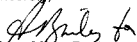
This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

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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