STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967441	**08/10/2016**
NAME OF PROVIDER OR SUPPLIER **PERSONALIZED HEALTH SERVICES CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **8510 SW 12TH STREET** **MIAMI, FL 33144**	

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

0000 Initial Comments

A Standard Biennial survey was conducted on . Personalized Health Services Corp, license number 11467, had deficiencies found at the time of the survey.

0007 Admissions - Criteria

Based on record review and interview the facility failed to ensure that 1 out of 6 (Resident #2) sampled residents met continuing residency criteria. The facility failed to ensure that Resident #2 did not have any communicable .

Findings include:

Record review found that Resident #2 was admitted to the facility on / / . The health assessment completed on showed that the resident has a communicable that can be transmitted to other residents or staff. The physician document that the resident has a diagnosis of Extended-Spectrum -Lacyamase (ESBL) . Track .

Interview conducted on / / at 2:10 PM, Staff D stated that Resident #2 received treatment at the hospital. She does not have a communicable at present.

There is no documentation of the control procedures implement by the facility to avoid that the could be transmitted to other residents and staff.

Class III

0077 Staffing Standards - Administrators

Based on record review and interview, the facility failed to appoint in writing a manager for the facility.

Findings include:

Review of facility finder showed the Administrator supervised two assisted living facility. Review facility's record showed the facility did not have a manager appointed.

Interview conducted on / / at 2:45 PM, Staff A, the Administrator confirmed that she did not appoint a manager for the facility.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Personalized Health Services Corp
8510 Sw 12th Street
Miami, FL 33144

Dear Administrator:

This letter reports the findings of a Standard Biennial 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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