**AGENCY FOR HEALTH CARE ADMINISTRATION**

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967920 | R<br>11/04/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**MACHIN II ALF, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**15863 SW 150 TERRACE**<br>**MIAMI, FL 33196** | |

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

**0000 Initial Comments**

A Change of Ownership Revisit survey was conducted on 11/04/2016. Machin II ALF, Inc with Limited Mental Health component (License #10562) had deficiencies found at the time of survey:

**0079 Staffing Standards - Levels**

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

Findings included:

Observation on / / at 10:00 AM showed Staff C was in care of the residents and providing personal services to them.

Staffing schedule review showed Staff C is scheduled to be in the facility from 7 AM-7 PM, Staff D is scheduled to be in the facility 7 PM- 7 AM, Staff E is scheduled to be at the facility from 8 AM-5 PM.

Interview conducted on / at 11:00 AM, Staff C, caregiver stated "Staff E is not working today."

Uncorrected

Class III

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| AL11967920 Y1 | A. Building<br>B. Wing Y2 | Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACHIN II ALF, INC | 15863 SW 150 TERRACE<br>MIAMI, FL 33196 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix A0030 | Correction | ID Prefix A0081 | Correction | ID Prefix A0082 | Correction |
| Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS | Completed | Reg. # 58A-5.0191(2) FAC | Completed | Reg. # 58A-5.0191(3) FAC | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix A0084 | Correction | ID Prefix A0167 | Correction | ID Prefix | Correction |
| Reg. # 58A-5.0191(5) FAC | Completed | Reg. # 58A-5.025 FAC | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) CQ | DATE 11/16/16 | TITLE HFES | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON 9/20/2016 | | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | | ☐ YES ☐ NO |



EVENT ID: C08512

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Machin Ii Alf, Inc
15863 Sw 150 Terrace
Miami, FL 33196

Dear Administrator:

This letter reports the findings of a Change of Ownership revisit survey conducted on , 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

BBT7

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