

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/13/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968136	(X3) DATE SURVEY COMPLETED 01/04/2017
NAME OF PROVIDER OR SUPPLIER LOVE OF HOPE ALF, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 NW 174TH STREET MIAMI GARDENS, FL 33056	

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

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview the facility failed to have documentation of a signed attestation of compliance in the personnel record for 3 out of 3 sampled employees (Staff A, B and C).

Findings included:

Personnel record review for Staff A, B and C revealed that none of them had the signed Attestation of Compliance in their record.

The administrator stated on 1/1/2017 at 10:12 am. "Is that new? Does everybody need one?"

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview the facility failed to maintain an updated employee roster in the Background Screening Database Clearinghouse.

Findings included:

Review of the staffing schedule revealed that there were 3 staff working at the facility (Staff A, B and C).

Review of the Clearinghouse revealed that the facility roster was empty.

The facility administrator stated on 1/1/2017 at 9:50 am, "I did not know I needed to do that."

Class III



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Love Of Hope Alf, Inc
2911 Nw 174th Street
Miami Gardens, FL 33056

RE: CCR #201601012386

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2017 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 , 2017.** 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 2016012386

XG90

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