STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911858	05/16/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Tropical Garden Villas Inc. (a	428 South 'F' Street Lake Worth, FL 33460	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D

Specific Tag Findings:

0000-Initial Comments

CCR#2013005172

Allegation was not confirmed. Tropical Garden Villas Assisted Living Facility is not in compliance with the Requirements for Assisted Living Facilities, unrelated to the allegation reviewed.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on record review and interviews it was determined that the facility failed to facilitate the right of residents to present grievances and recommend changes in facility's policies, procedures and services.

The findings include:

A review of the facility's grievance policy on [redacted] revealed a meeting held monthly would be used as a medium for the residents to express themselves with complaints and or grievances pertaining to any issue within the facility and that staff has the responsiblity of initiating the meetings and documenting the grievances and complaints voiced byt the residents. Staff was also endowed with the added responsiblity of documenting any and all interventions done to achieve a satisfactory resolution of each grievance/complaint.

Review of the documentation of monthly meetings held for the past 6 months revealed six suggestion forms from various residents. The forms were noted to be undated. An interview was conducted with the Administrator on [redacted] at approximately 11:01 AM during which he stated that he had no further documentation and that he could not determine what months the suggestion forms were submitted by the resident and that there was no available documentation of any interventions done on the part of facility staff to achieve a satisfactory resolution to the concerns voiced by the residents.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911858	**05/16/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0079-Staffing Standards - Levels 58A-5.019(4) FAC

Based on record review and interview, the facility failed to maintain a current written work schedule which accurately reflects its 24-hour staffing pattern.

The findings include:

Review of the posted staffing schedule revealed the staffing schedule was not dated for the current week. It was noted that four employees (Employees #1, #2, #3 and #4) were scheduled to work in the facility.

Further record review revealed Employee #4 was scheduled to work on from 8:00 AM-8:00 PM. Employee #4 was observed to be in his 9:00 AM until 1:10 PM. Employee #4 at 1:10 PM was observed to emerge from his as a security guard and was observed leaving the facility. The employee did not work his assigned work schedule for the aforementioned date.

An interview was conducted with Employee #4 on at approximately 1:15 PM during which he confirmed that he works Monday thru Friday as a security guard outside of the facility and should not have been included on the facility's work schedule to work those days.

In an interview with the staff member in charge on at 1:20 PM, she confirmed the findings and stated that no further information was available for review.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Tropical Garden Villas Inc.
428 South 'F' Street
Lake Worth, FL 33460

Dear Administrator:

Re: CCR #2013005172

This letter reports the findings of a complaint survey that was conducted on , 2013 by a representative from this office. Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after , **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924