STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967048	08/24/2015
NAME OF PROVIDER OR SUPPLIER **TYVAL ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3526 GENEVRA AVE** **BOYNTON BEACH, FL 33436**	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted at Tyval Assisted Living Facility. Tyval Assisted living facility had a deficiency found at the time of the visit.

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to ensure that 2 of 3 employees (Staff B and C) had completed one hour of required training on resident rights.

The Findings Include:

Record review of personnel files was conducted on . Staff B , a Home Health Aide and Staff C a Home Health Aide did not have a certificate in their files reflecting completion of a one hour training on resident rights. During an interview with the Administrator conducted on at 2:45 PM, she acknowledged the findings and stated no further documentation was available to review.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Tyval Assisted Living Facility
3526 Genevra Ave
Boynton Beach, FL 33436

Dear Administrator:

This letter reports the findings of a state Relicensure survey that was conducted on , 2015 by a representative 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 , 2015.** 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 this office at 561 381-5840.

Sincerely,

Arlene d-Davis
Field Office Manager

AMD/sf
Enclosure
XG90

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