AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910781	01/27/2016
NAME OF PROVIDER OR SUPPLIER **TYRONE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2192 74TH STREET, NORTH** **SAINT PETERSBURG, FL 33710**	

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

0000 Initial Comments

Assisted Living Facility

A biennial relicensure survey was conducted at Tyrone Manor on /_ . . . . Tyrone Manor, Assisted Living Facility, had a deficiency at the time of the visit.

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to provide the required in-service training's to 1 of 3 sampled direct care staff (#C) within thirty (30) days of employment.

Findings included:

Record review of staff #C's (hire date: of 2015) personnel file on / revealed there was no documentation stating the following in-services had been completed within the 30 days of employment. The missing training's were ADL and behavioral needs training, training, elopement response training, emergency preparedness & evacuation training, recognizing/reporting ,neglect & training and policy and procedure training.

When interviewed on /_ at 2:00 p.m., the owner stated that the staff would require additional training. He confirmed that the training's had not been completed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Tyrone Manor
2192 74th Street, North
Saint Petersburg, FL 33710

Dear Administrator:

This letter reports the findings of a biennial state 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 Paul Brown, HHES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/c;t
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com