

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 03/15/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953384	(X3) DATE SURVEY COMPLETED 03/08/2016
NAME OF PROVIDER OR SUPPLIER COURTYARD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W 28 STREET HIALEAH, FL 33010	

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

0000 Initial Comments

A Standard Biennial Survey was made on _____ and _____. Courtyard Manor had the following deficiency at the time of the visit:

L243 LMH - Training

Based on record review and interview, the facility failed to have 2 of 6 sample employees (Staff C and D) trained in a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.

Findings as follow:

Record review documented the facility failed to have documentation of the 6 hours Limited Mental Health training for Staff C (hired on ____/____/____) and Staff D (hired on ____/____/____).

On _____ the facility administrator acknowledged that Staff C and Staff D had not received a minimum of 6 hours of training regarding working with limited mental health residents.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Courtyard Manor
140 W 28 Street
Hialeah, FL 33010

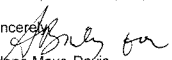
Dear Administrator:

This letter reports the findings of a 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/sb
Enclosure
XG90

