STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	05/18/2016
NAME OF PROVIDER OR SUPPLIER **MIDTOWN MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2001 POLK STREET** **HOLLYWOOD, FL 33020**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016001639 , was conducted on 5/11/16 and 5/18/16 at Midtown Manor. The facility had unrelated deficiencies at the time of the investigation.

Z814 Background Screening Clearinghouse

Based on record review ,observation and interview, the facility failed to maintain the employment status of all employees within the clearinghouse for initial employment status and any changes in status within 10 business days.

The findings include:

A review of the facility staffing schedule dated - / / revealed that the facility has 28 current staff members on the schedule.

In observations conducted on / throughout the day from 9:30 AM -3:30 PM , 11 of the 28 staff members were present and were observed conducting their assigned duties.

A review of the Agency for Healthcare Administration background screening website revealed that the facility only listed four employees as active.

In a side by side review and interview with the Administrator, conducted on / / at 2:00 PM of the Agency for Healthcare Administration background screening roster for the facility ,she stated that 3 of the 4 employees listed on the roster were no longer employed by the facility and had been gone for much longer than 10 days, she did not know exact dates of termination. She also confirmed that none of the 28 current employees were listed on the roster.

unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Midtown Manor
2001 Polk Street
Hollywood, FL 33020

RE: CCR #2016001639

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 , 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 representative. Should you have any questions please call this office at 561-381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dlt
Enclosure

XG90

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