STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965494	05/12/2016
NAME OF PROVIDER OR SUPPLIER **CORAL PARK SENIOR CARE OF MIAMI**	STREET ADDRESS, CITY, STATE, ZIP CODE **9640 SW 10 TERRACE** **MIAMI, FL 33174**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on , 2016. Coral Park Senior Care of Miami with Limited Mental Health component had a deficiency identified at the time of the survey.

L243 LMH - Training

Based on record review and interview, the facility failed to ensure that staff in direct contact with mental health residents, and who took the initial 6 hours training in limited mental health complete a minimum of 3 hours of continuing education related to their duties for 2 out of 5 sampled employees (Staff D and E).

Findings included:

Employee record review revealed that Staff D had a initial limited mental health training on / ; a 3 hours of continuing education training in limited mental health was not found on her record.

Employee record review revealed that Staff E had an initial limited mental health training on / ; 3 hours of continuing education training in limited mental health was not found on her record.

The administrator stated on at 10:30 am that she will make sure that Staff D and E receive 3 hours of continuing education related to limited mental health topics.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Coral Park Senior Care Of Miami
9640 Sw 10 Terrace
Miami, FL 33174

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, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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