STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965703	07/13/2016
NAME OF PROVIDER OR SUPPLIER **MARTIN RESIDENCES, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **19940 SW 124 COURT** **MIAMI, FL 33177**	

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

0000 Initial Comments

A Limited Mental Health Component Expansion Survey was conducted on . Martin Residences, Inc. with a standard license (#10058) had the following deficiency found at the time of the survey.

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to appoint a separate Manager for the facility who did not administer any other facilities.

Findings included:

On at 9:00 AM record review revealed that the facility had not appointed a Manager. The facility's Administrator supervised two facilities.

On at 9:45 AM PM during an interview with the Administrator over the phone, he was informed that he was going to be cited because he had not appointed a manager for this facility because he was the Administrator at two facilities. He stated that he was going to take care of it as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Martin Residences, Inc
19940 Sw 124 Court
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a Limited Mental Health component 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 Arlene Mayo-Davis, RN at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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