STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953384	08/16/2016
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 Financial Monitoring survey was conducted on , 2016. Courtyard Manor Retirement (License # 5947) had the following deficiency at time of the survey:

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview the assisted living facility failed to provide a safe living environment and an environment free of hazards.

Findings included:

Observation on at 11:20 am showed that (2- 17) needed to clean or replace the vent of the Air Conditioner (AC); they had black stains that appeared to be mold. Also, the light bulbs were too dim, and were dark.

Observations on at 11:30 am showed that # needed tohave the repair of it's ceiling completed. # was missing the AC vent. # 's hallway had peeling paint, # AC ' s door was dirty and missing tile.

Further observation on at 11:47 am showed # had a wall with black stain that appeared to be mold.

Observation on at 12:00 pm revealed that the dining area was leaking water, and there were three containers with a piece of fabric on the bottom to catch the running water from the ceiling.

Interview on at 1:00 pm Manager acknowledged that facility needed to repaired in the areas mentions above, and she also stated, " It will be repaired. "

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 financial monitoring 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 Arlene Mayo-Davis, RN at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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