

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/23/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922197	(X3) DATE SURVEY COMPLETED 09/15/2016
NAME OF PROVIDER OR SUPPLIER CAMELOT COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 MCKINLEY STREET HOLLYWOOD, FL 33020	

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

0000 Initial Comments

An unannounced abbreviated Relicensure survey was conducted on _____ at Camelot Court, (License #7096). The facility had deficiencies at the time of the visit.

0078 Staffing Standards - Staff

Based on interview and record, it was determined the facility failed to ensure that each staff member had documentation/evidence of a negative _____ () examination annually, for 1 out of 3 staff members (Staff A).

The findings include:

Record review of Staff A's personnel record revealed her date of hire was _____. Further review revealed Staff A's file lacked annual documentation since ____ from a physician indicating the employee is free from _____.

In an interview with Administrator on ____ at approximately 1:05 PM, she acknowledged the findings and stated no further documentation was available for review.

Class III

0082 Training - /

Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff members (Staff B) had obtained an initial training on ____ within 30 days of employment.

The Findings Include:

A record review conducted for Staff B, hired on ____ / ____, revealed no documentation of an initial training on ____ / ____ within 30 days of employment.

An interview conducted on ____ at approximately 1:30 PM, the Administrator acknowledged the findings and stated no further documentation was available for review.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 1, 2016

Administrator
Camelot Court
2233 McKinley Street
Hollywood, FL 33020

RE: Relicensure Survey

Dear Administrator:

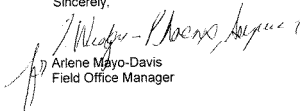
This letter reports the findings of a state Relicensure survey that was conducted on September 1, 2016 by a representative of this office.

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 3, 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
Enclosure

XG90

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