STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911858	**11/01/2016**
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (A**	STREET ADDRESS, CITY, STATE, ZIP CODE **428 SOUTH 'F' STREET** **LAKE WORTH, FL 33460**	

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

0000 Initial Comments

An unannounced initial Limited Mental Health licensure survey was conducted on 11/1/16 at Tropical Garden Villas Inc.(License # 7903). The facility had a deficiency found at the time of the visit.

0077 Staffing Standards - Administrators

Based on record review and interview, the facility failed to ensure that an Administrator who supervises more than one facility appoint in writing a separate Manager for each facility who is not a Manager at another facility or who is not an Administrator of any other facility and has completed the core training and core competency test requirements within 90 days after becoming employed as a Manager.

The findings include:

A review of the Florida Health Finder website revealed that the Administrator/Staff B is listed as the Administrator of 3 assisted living facilities (Facility A, B and C).

In an interview conducted with the Administrator on 11/01/16 at 11:30 AM during the entrance conference, he confirmed that he is the Administrator of three assisted living facilities, and that he does not have an appointed core trained Manager at this facility.

During exit conference at around 1 PM on / , the Administrator acknowledged the finding and stated no futher information was available for review.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Tropical Garden Villas Inc. (a
428 South 'F' Street
Lake Worth, FL 33460

Re: Initial Limited Mental Health Survey

Dear Administrator:

This letter reports the findings of an Initial Limited Mental Health 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,

Mayo-Davis
Field Office Manager

AMD/dmb

XG90

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