

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967082	(X3) DATE SURVEY COMPLETED 11/24/2014
NAME OF PROVIDER OR SUPPLIER Good Time Home Care	STREET ADDRESS, CITY, STATE, ZIP CODE 8640 Sw 185 Street Miami, FL 33157	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

Specific Tag Findings:

0000-Initial Comments

A Complaint Investigation Survey (CCR # 2014010402) was conducted on . Good Time Home Care had deficiencies at the time of the survey.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record review and interview the facility failed to provide a Health Assessment for 1 out of 3 sampled resident's record reviewed (Resident #2).

The findings include:

Review of Resident #2 (admitted on) record on at 10:45 AM showed it did not contain the require health assessment form (AHCA Form 1823).

During an interview on at 2:20 PM, the facility administrator stated that in-fact the examining physician had not completed the health assessment for Resident #2.

Class III

0160-Records - Facility 58A-5.024(1) FAC

Based on observation, record review and interview the facility failed to have proof of a satisfactory annual fire inspection.

The findings include:

Review of facility record on at 9:00 AM showed a fire inspection dated had one violation.

During an interview on at 2:30 PM, the facility administrator stated they corrected the violation but they are waiting for the re-inspection.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUKE
SECRETARY

2014

Administrator
Good Time Home Care
8640 Sw 185 Street
Miami, FL 33157

RE: CCR #2014010402

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 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.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure 2014010402

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