| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964652 | 01/13/2015 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Grandad Elderly Corp | 7520 Sw 108 Avenue Miami, FL 33173 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

**Specific Tag Findings:**

**0000-Initial Comments**

A standard biennial survey was made on / . Grandad Elderly Corp had the following deficiency at the time of the visit.

**0162-Records - Resident 58A-5.024(3) FAC**

Based on record review and interview the facility failed to have a Power of attorney for 1 of 2 ( #3) facility sample residents. Record review documented the facility failed to have the orders for diet for 1 of 2 (#3) facility sample residents.

Findings as follow:

Record review showed the admission documents, including the contract between the facility and resident #3 (admitted on / ).were signed by a family member of rsident #3. Record review showed the facility failed to have a Power f / for resident #3.
Record review also showed the facility failed to have a resident #3's health assessment with orders for diet .

On / at 11:00 a.m. the facility administrator acknowledge a family member signed the admission doc n luding the contract for resident #3 and stated the facility failed to have a power of attorney and the orders for diet for resident #3.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Grandad Elderly Corp
7520 Sw 108 Avenue
Miami, FL 33173

Dear Administrator:

This letter reports the findings of a standard biennial survey that was conducted on 2015 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
XG90

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