STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966148	01/27/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Time Is Care	19010 Nw 44 Avenue Opa Locka, FL 33055	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

Specific Tag Findings:

0000-Initial Comments

Medicaid Program Integrity (MPI) and Health Quality Assurance (HQA) conducted a monitoring visit on [illegible] Maggie's Retirement Home #4 had no deficiencies at the time of the visit. Time is Care had a deficiency at the time of the survey.

0054-Medication - Records 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to maintain completed residents medication observation records for 5 of 5 (1, 2, 3, 4 and 5) sampled residents who received assistance with self-administration of medication from the facility staff.

The findings included:

Review of Residents #1, 2, 3, 4 and 5's medication observation records indicated that the facility did not document the medications the facility staff assisted the residents with on [illegible] in the evening and on [illegible] in the morning.

In an interview with the Administrator on [illegible] at 9:25 am, she stated that all the facility residents received their medications on [illegible] and [illegible] but she forgot to document this on their medication observation records.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Time Is Care
19010 Nw 44 Avenue
Opa Locka, FL 33055

Dear Administrator:

This letter reports the findings of a Monitoring 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
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