STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953385	**05/01/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MY GRANDFATHER HOME CARE	**3042 SW 134 PLACE MIAMI, FL 33175**	

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

0000 - Initial Comments

An Abbreviated Biennial survey was conducted on , 2015 and concluded on , 2015. My Grandfather Home Care had the following deficiencies at time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview the facility failed to ensure that two out of six sample residents (1 and 4) had an accurate and completed health assessments.

Findings included:

Record review on at 11:50 am revealed that Resident 1's health assessment (dated on) indicated that Resident (1) needed 24-hours nursing or care services.

Record review on revealed that Resident 4's health assessment (dated on) indicated that Resident 4 needed administration of medication and the elopement risk information was blank.

Interview on at 1:00 pm the Administrator acknowledged that Residents 1 and 4's health assessments was not accurate and completed.

Class III

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

Based on record review and interview the facility failed to maintain completed Medication Observation Record (MOR) for one out of six (6) sampled residents who received assistance with self-administration of medication from the facility's staffing.

Findings included:

Record review on revealed that the MOR indicated that the facility did not give Resident #6's his medication the evening ( ) and morning ( ). The MOR was not initialed by staff.

Interview on at 1:51 pm Resident #6 stated, "Staff provided my medications last night and this morning early, on time."

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953385	05/01/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MY GRANDFATHER HOME CARE	3042 SW 134 PLACE MIAMI, FL 33175	

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

0160 Continued From page 1

Based in observation, record review, and interview the facility failed to ensure the facility Admission / Discharge log was updated.

Findings included:

Observation on at 9:00 am revealed that the facility had six residents at the time of survey.

Facility record review on at 9:20 am revealed the Admission/Discharge log did not have Resident 6 listed.

Interview on with Resident 6 revealed that she lived in the facility. Resident 6 also stated that she had her medications, meals, and staff assist her.

Interview on at 10:00 am the Administrator admitted that Resident #6 lived in the facility since but she was still adapting to the facility.

Class III

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

Based on observations, record review, and interview the facility failed to have a completed resident contract and a signed consent for unlicensed employee to assist with self- administration of medication.

Findings included:

Facility record review on at 10:00 am revealed that Resident 6 (admitted on) did not have a contract. Also, Resident #6 did not have a signed consent to be assisted with self-administration of medications for an unlicensed staff.

An interview on at 1:51 pm with Resident #6 revealed that she stated, "A Staff provided my medications last night and early this morning, on time. "

Interview on at 1:00 pm with Administrator revealed that Resident #6 lived in the facility since in #_.

Class III

0189 - ADCCs in ALF - FS 429.905 (2); 58A-6.013 (2-3) FAC

Based in observation, record review, and interview the facility failed have authorization to provide day care services.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953385	05/01/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
MY GRANDFATHER HOME CARE	3042 SW 134 PLACE MIAMI, FL 33175	

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

0189 Continued From page 2

Findings included:

Observation on at 8:30 am revealed there were five daycare participants (7-11) at the assisted living facility.

Observation revealed two daycare participants were seating in the main dining (7 and 10) and three daycare participants (8, 9, and 11) were seating in the backyard during the survey.

Observation on at 9:00 am revealed a white stapled bag on the top of the desk (kitchen/dining) with medications the followings medications: 600 milligrams (mg), Vit D, Mult- , Omega- 3 1000 mg, and Vit C these medications belonged to Participant #8.

Observation on at 9:10 am inside the caregiver's three brown paper bags on the floor full of medications which belongs to Residents (#1-5) and Participant #7.

Participant #7 had the following medications: 81 mg, SOD 100 MG, 1 mg, Levetriracetam 500 mg (8:00 am - 8:00 pm), , 20 mg, 10 mg (8:00 am -8:00 pm) , Pantoprazol 40 mg, 150 mg, , 0.5 mg (8:00 am, 4:00 pm, 12:00 pm), 40 mg (8:00 pm) , , 15 mg (8:00 pm), Desyrel 50 mg tablet (8:00 am) and B-1 100 MG (8:00 AM).
Interview with the Administrator on at 9:15 am, she stated employee's locked. She also stated that Participant #8's medications will be pick up for her daughter. The Administrator stated, " I am just doing a favor for the families."

Record review on / revealed that facility finder website revealed that the facility did not have a daycare services.

Interviews on / between 12:00 pm -12:45 pm revealed that the family members admitted that Participants 7, 10, and 11 were receiving daycare services in the facility at time of survey.

Interview on / at 10:00 am the staff revealed that there were five daycare participants.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
My Grandfather Home Care
3042 Sw 134 Place
Miami, FL 33175

Dear Administrator:

This letter reports the findings of an Abbreviated Biennial licensure survey that was concluded 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
XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com