

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/13/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942921	(X3) DATE SURVEY COMPLETED 10/26/2015
NAME OF PROVIDER OR SUPPLIER COMPANION HOME CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 1997 SW 17 COURT MIAMI, FL 33145	

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

0000 Initial Comments

A Extended Congregate Care Monitoring Survey was conducted on , 2015. Companion Home Corp with Extended Congregate Care and Limited Mental Health component had the following deficiency identified at time of survey.

0079 Staffing Standards - Levels

Based on observation and record review, the Assisted Living Facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for the current period of time period.

Findings include:

Observation on at 11:42 AM revealed that Caregiver A and Caregiver B were the two caregivers presented at time of arrival at the facility.
Observation on at 12:40 PM revealed that Administrator posted the new job scheduled while on survey for week thru / / .

Administrator arrived to facility on at 12:10 PM
In an interview with Caregiver A on at 12:07 PM revealed that job schedule for current week was not done yet.

Record review revealed that staff schedule posted in the sitting area revealed staffing patterned was for week thru .

New schedule reflected that Caregiver A on from 7 AM to 5 PM, Administrator from 7 AM to 5 PM and Caregiver B from 9 AM to 5 PM.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 15, 2015

Administrator
Companion Home Corp
1997 Sw 17 Court
Miami, FL 33145

Dear Administrator:

This letter reports the findings of a Extended Congregate Care Monitoring Survey that was conducted on January 15, 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. **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 January 29, 2015.** 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 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

