STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942921	01/26/2016
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 complaint (2016000871) survey was conducted on , 2016. Companion Home Corp with Extended Congregate Care and Limited Mental Health components had the following deficiencies identified at time of survey:

0030 Resident Care - Rights & Facility Procedures

Based on observations and interview the facility failed to ensure that 6 of 6 (#1-6) sampled residents were treated with consideration during temperature changes in the weather.

Findings included:
Observation on / at 6:30 a.m. revealed a portable heated in Resident #10, and there were two in the linen closet. Observation on / at 6:48 am found Resident #7 had two blankets and a sweeter on. Observation on / / from 6:30 a.m. to 8:00 a.m. revealed residents were covered by multiple blankets while in bed.
Interview on / at 6:48 a.m. Resident #7 stated, "I felt during the last two days, I even have to put my sweeter on to sleep. I would like that the facility do something here to not feel that ."
Interview on / at 6:56 a.m. Resident #8 stated, "There is in here; there is no calefaction, I would like that the facility provides a better environment when the weather dropped down."
Interview on / at 7:00 a.m. Resident #10 stated, "I am , I have been here for 15 years, and I love this place. I have my own heater, but the facility was ; I also have my own covers.
Interview on / at 8:20 a.m. Resident #1 stated, " I have my own covers, there is no heater; I just covers well myself."
Interview on / at 8:28 a.m. Staff B stated, "We turn off the air condition. We have not put the heater because it is not necessary, and nobody has complained about low temperature. We also provide extra covers for the residents. Nobody told me regarding ."
Interview on / at 8:35 a.m. Staff B stated," We have not put the heater in these days because it has not been necessary. I have no restriction to put the heater. I just covers them well, we have many covers, and the heater has no problem. Also, I have a resident (#10) that she does not like the heating because she has . Therefore, the was only two days; we turn off the AC. We provide them hot drinks (coffee/chocolate), and nobody has complained about ."
Interview on / at 8:38 a.m. Staff C stated, " I have been working in the facility for about a year. I have put the heating; I put the heat on 84 degree."
Interview on / at 10:00 a.m. the Administrator stated, "I did not know that they were , I do not have problem to put the heater, it is not a problem to me."
Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0152 Phvsical Plant - Safe Living Environ/Other

Based on observation and interview the facility failed to ensure the the air conditioner (AC) was in good working order.

Findings included:

During the facility tour on I/ at 9:10 AM found the AC vent in 3, 4, and living what appeared to be mold. Also, on I/ at 10 AM found the AC vents were not sending air in resident 1, 3, and 4.

Interview on I/ at 10:00 a.m. the Administrator stated, "I will call a technician to repair the AC vents and take out the mold."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Companion Home Corp
1997 Sw 17 Court
Miami, FL 33145
RE: CCR #2016000871

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was conducted on 26, 2016 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 , 2016.** 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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