| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967575 | 09/06/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**EXCELLENT GRANDPARENTS PLACE, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**13342 SW 6 STREET**<br>**MIAMI, FL 33184** | |

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

**0000 Initial Comments**

A Standard Biennial Survey was conducted on . Excellent Grandparents Place, Inc. with Limited Mental Health License #11639, had the following deficiency at the time of the survey:

**L243 LMH - Training**

Based on record review and interview the facility failed to ensure that two out of four sampled employees (Staff C and D) received the 6/hours initial training and the continuous education training for Limited Mental Health.

Findings included:

On at 11:00 AM record reviewed of Staff C. (hire date ) revealed that she had not taken the initial 6/hours LMH training, and Staff D (hired date ) she had taken the initial 6/hours dated / , but she had not taken the required 3 hours of continuing education.

On at 11:15 AM, the Administrator stated that it was impossible for her to sign these two caregivers up for the training in and that they were going to have it in .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Excellent Grandparents Place, Inc
13342 Sw 6 Street
Miami, FL 33184

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 6, 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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