STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942934	**10/14/2016**
NAME OF PROVIDER OR SUPPLIER **GRAND COURT ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **295 SW 4TH AVENUE** **POMPANO BEACH, FL 33060**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016008079, was conducted on 10/14/16 at Grand Court ALF. License # 5464. The facility had deficiencies at the time of the investigation.

0160 Records - Facilitv

Based on record review and interview, the facility failed to ensure that the facility's admission and discharge log contained the required elements. As evidenced by not indicating the facility or place from which the resident was admitted,the facility or home address to which the resident was discharged and the date of for residents that die while in the care of the facility.

The findings include:

A review conducted on at 11:30 AM, of the facility's admission/ discharge log from / - , titled "Admission/ Discharge log "revealed the form lacked , the identification of the facility or home address to which the residents are discharged, and in the case of the of the resident at the facility, the resident's date of .

In an interview conducted on at 4:18 PM with the Administrator, she confirmed the findings.

Class

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Grand Court Alf
295 SW 4th Avenue
Pompano Beach, FL 33060

RE: CCR #2016008079

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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