| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966148 | R<br>11/08/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**TIME IS CARE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**19010 NW 44 AVENUE**<br>**OPA LOCKA, FL 33055** | |

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

**0000 Initial Comments**

A Complaint Survey Revisit CCR#2016006948 was conducted on 08, 2016. Time is Care, Corp. (#10391) with Limited Mental Health component had deficiencies identified at the time of the survey.

**0025 Resident Care - Supervision**

Based on record review and interview the facility failed to maintain a written record of a significant change after a resident eloped and was brought back to the facility by the police. (Resident #1 ).

Findings included:

Record review of Resident # 1's file revealed that there were no notes written regarding the the resident's elopement on some date between / - /.

On / / at 10:25 am Staff D stated that they will write the notes regarding Resident # 1's elopement and that they will send the incident report to AHCA.

On / / at 10:36 am Staff B stated, " I remember that Resident # 1 left on because it was the day of my birthday and when the police brought her back he wished me a happy birthday."

Uncorrected
Class III

**0165 Risk Mgmt & QA: Adverse Incident Report**

Based on record review, and interview the facility failed to report an initial adverse incident report within one business day after the incident and full adverse incident report within 15 days of the incident for 1 of 6 sampled residents (Resident # 1).

Findings included:

Record review revealed that there was no incident report regarding Resident # 1 ' s elopement from the facility during the period between / and .

A review of facility records and the incident report database revealed that no report regarding the elopement of Resident # 1 had been electronically filed.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966148** | R<br>**11/08/2016** |
| NAME OF PROVIDER OR SUPPLIER<br>**TIME IS CARE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**19010 NW 44 AVENUE**<br>**OPA LOCKA, FL 33055** | |

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

On 11/08/16 at 10:25 am Staff D stated that they will write the notes regarding Resident # 1's elopement and that they will send the incident report to AHCA.

Uncorrected
Class III

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| AL11966148 Y1 | A. Building<br>B. Wing Y2 | Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TIME IS CARE | 19010 NW 44 AVENUE<br>OPA LOCKA, FL 33055 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix A0031 | Correction | ID Prefix A0055 | Correction | ID Prefix A0078 | Correction |
| Reg. # 58A-5.0182(7) FAC | Completed | Reg. # 58A-5.0185(6) FAC | Completed | Reg. # 58A-5.019(2) FAC | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix A0152 | Correction | ID Prefix A0162 | Correction | ID Prefix | Correction |
| Reg. # 58A-5.023(3) FAC | Completed | Reg. # 58A-5.024(3) FAC | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE 12/2/16 | TITLE HFES | DATE |

FOLLOWUP TO SURVEY COMPLETED ON 9/9/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Time Is Care
19010 Nw 44 Avenue
Opa Locka, FL 33055

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 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 , 2017.** 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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