STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942921	**01/24/2017**
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)

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview the facility failed to have a signed Attestation of Compliance with Background Screening in the personnel record for 6 of 6 sampled employees (Staff A, B, C, D, E and F).

Findings included:

Personnel record review of Staff A, B, C, D, E and F revealed that none of them had the signed Attestation of Compliance with Background Screening in their record.

On / at 1:05 pm the administrator stated that nobody had told her that she needed the attestation of compliance and that she would ask the consultant for the form to give it to all her employees to sign.

Unclassified

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0000 - Initial Comments

A Extended Congregate Care Monitoring Survey was conducted on January 24, 2017. Companion Home Corp. (License # 7893) with Extended Congregate Care and Limited Mental Health components had a deficiency identified at the time of the survey:

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

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

Dear Administrator:

This letter reports the findings of an Extended Congregate Care state licensure survey that was conducted on , 2017 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

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida