

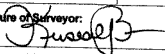
State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968548	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/9/2013
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Name of Facility HEAVENLY HOME CARE OF FLORIDA, INC	Street Address, City, State, Zip Code 17321 SW 109 AVENUE MIAMI, FL 33157
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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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed 05/09/2013	ID Prefix <u>A0032</u> Reg. # <u>58A-5.0182(8) FAC</u> LSC _____	Correction Completed 05/09/2013	ID Prefix <u>A0052</u> Reg. # <u>58A-5.0185(3) FAC</u> LSC _____	Correction Completed 05/09/2013
ID Prefix <u>A0079</u> Reg. # <u>58A-5.019(4) FAC</u> LSC _____	Correction Completed 05/09/2013	ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed 05/09/2013	ID Prefix <u>A0164</u> Reg. # <u>58A-5.024(4) FAC</u> LSC _____	Correction Completed 05/09/2013
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: <u>05/20/2013</u>
Reviewed By _____ CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 12/18/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 4, 2013

Administrator
Heavenly Home Care Of Florida, Inc
17321 Sw 109 Avenue
Miami, FL 33157

CCR#2012011756 2nd f/u

Dear Administrator:

This letter reports the findings of a state complaint 2nd revisit survey conducted on May 9, 2013 by representative(s) of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,


for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

J5XD

