STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966548	**10/22/2013**
NAME OF PROVIDER OR SUPPLIER **Heavenly Home Care Of Florida, Inc**	STREET ADDRESS, CITY, STATE, ZIP CODE **17321 Sw 109 Avenue Miami, FL 33157**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D

Specific Tag Findings:

0000-Initial Comments

A standard biennial survey was conducted on . Heavenly Home Care of Florida had the following deficiency at time of survey.

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on record review and interview the facility failed to follow a written medication order for 1 of 5 (#2) facility residents as follow:

Findings Include:

Record review Medication Observation Record (MOR) for resident #2 documented the following medication:
Chlorexidine 0.12 % was prescribed as follow:
Swish with 15 ml for 30 seconds twice a day from till then stop

Further record review (MOR) documented the medication was maked as administered till , 8:00 a.m..

On at about 12:00 noon the facility administrator stated had no the written order to continue with the medication administration after

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 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.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121