STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967293	**11/05/2013**
NAME OF PROVIDER OR SUPPLIER **Helping Hand Assisted Home Care Llc**	STREET ADDRESS, CITY, STATE, ZIP CODE **4406 Sw 129 Avenue Miami, FL 33175**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

Specific Tag Findings:

0000-Initial Comments

An unanounced Limited Nursing Services Monitoring survey was performed at Helping Hand Assisted Home Care Llc on , 2013. Deficiency was identified at time of survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and interview facility failed to document a significant change on form 1823 for 1 out of 4 sampled residents (#1).

Findings include:

Record review of resident # 1 realed that resident has been receiving hospices services since . Record review also revealed that the last health assessment was done on and resident needed asistance with all ADL's. At this time resident is on hospice, she is not able to walk, needs to be fed mostly, needs to be bathed and to be dressed. These significant changes are not reflected in the 1823.

Interviewed administrator on the phone on at 12:30 pm and she stated: "I will call the physician to come and do a new health assessment on the resident, I did not know that she needed a new one, I thought that the hospice documentation was enough."

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Helping Hand Assisted Home Care Llc
4406 Sw 129 Avenue
Miami, FL 33175

Dear Administrator:

This letter reports the findings of a state Limited Nursing Services (LNS) Monitoring 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