

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 03/17/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966338	(X3) DATE SURVEY COMPLETED 02/18/2014
NAME OF PROVIDER OR SUPPLIER J C Loving Home	STREET ADDRESS, CITY, STATE, ZIP CODE 781 East 45 Street Hialeah, FL 33013	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Standard Biennial survey was conducted on . J C Loving Home Assisted Living Facility had deficiencies found at the time of the visit

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review, and interview the facility failed to ensure 1 out of 6 residents have a physician order and consent for the use of half bed rails.

Findings includes:

Observation of resident #5 there were two half bed rails on his. (Photo was taken for evidence.)

Record review revealed there was no physician order or signed consent for the use of the half bed rails.

Interview with caretaker B. on at 11:55 am, confirmed the findings in regards to resident not having a signed and dated consent form and there was not any signed prescription for the two half rails found on his bed during the tour.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2014

Administrator
J C Loving Home
781 East 45 Street
Hiialeah, FL 33013

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on _____, 2014 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

