

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11932590	(X3) DATE SURVEY COMPLETED 08/05/2014
NAME OF PROVIDER OR SUPPLIER Our Loving Mother Elderly Care, Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 1635 West 65 Street Hialeah, FL 33012	
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

A Limited Nursing Services Monitoring Survey was conducted on , 2014. Our Loving Mother Elderly Care, Inc. had deficiencies identified at time of the survey.

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 have evidence to show that the order for half side rails were reviewed by a doctor annually for 1 out of 2 sampled residents (#1).

Findings included:

On during tour of the facility at 8:35 am observed resident # 1's with half bed rails. The caregiver stated during the tour "resident # 1 uses half bed rail."

Record review revealed that resident # 1 prescription for half bed rail was written on .

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 13, 2014

Administrator
Our Loving Mother Elderly Care, Inc
1635 West 65 Street
Hialeah, FL 33012

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring survey that was conducted on January 13, 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 thirty days 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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



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