STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	01/26/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Professional Home Care Iii, Inc	447 East 26 Street Hialeah, FL 33013	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial survey was conducted on 1/ . Professional Home Care III had deficiencies at the time of the survey.

0025-Resident Care - Supervision 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to provide written records, of significant changes or illnesses which resulted in medical attention (hospitalization) of 1 out of 14 (Resident # 6) sampled residents.

The findings included:

Record review on 1/ at 10:30 AM showed that Resident #6 was sent to the hospital due to hip . There was no written record or documentation that her family members and health care provider were notified.

During an interview on 1/ at 9:20 AM, Resident #6, stated "I felt few months ago and had a hip ."

During an interview on 1/ at 1:10 PM, the facility's Administrator stated " we notified her primary physician and her family members". She confirmed that Resident #6 and had a hip . She acknowledged that the facility did not have written records that that the family members and health care provider were notified.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Professional Home Care Iii, Inc
447 East 26 Street
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on , 2015 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 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