

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966463	(X3) DATE SURVEY COMPLETED 01/26/2015
NAME OF PROVIDER OR SUPPLIER J C Loving Care	STREET ADDRESS, CITY, STATE, ZIP CODE 11260 Sw 176 Street Miami, FL 33157	
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 Medicaid Program Integrity (MPI) and Health Quality Assurance (HQA) monitoring survey was conducted on J C Loving Care Corp had the following deficient practice found at time of survey.

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

Based on observation, interview and record review the assisted living facility failed to obtain a physician order authorizing the use of a half bedrails for 1 of 3 (Resident #1) sampled residents.

Findings include:

On half bed rails was observed attached to Resident #1 's bed.

On at 12:45 PM an interview was conducted with the facility administrator. The administrator stated she was unable to locate an order for Resident #1 's bed rail.

A record review of Resident #1 's file was conducted. No evidence was located in Resident #1 file that the observed bed rail was ordered by a physician.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
J C Loving Care
11260 Sw 176 Street
Miami, FL 33157

Dear Administrator:

This letter reports the findings of a Medicaid Program Integrity and Health Quality Assurance monitoring 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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure

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