STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964038	02/04/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Peace Home Care, Inc	5040 Nw 197 Street Miami, FL 33055	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

A Limited Nursing Services Monitoring Survey was conducted on , 2015. Peace Home Care, Inc. had a deficiency at time of the survey.

0010-Admissions - Continued Residency 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview facility failed to ensure that as part of the continuing residency criteria a resident has a new face to face medical examination (AHCA form 1823) by a health care provider after a significant change for 1 out of 3 sampled residents (#3).

Findings included:

Record review of Resident #3's record revealed that resident was admitted to hospice on I/ . Health assessment was done on and stated that the resident required assistance with all her activities of daily living and did not reflect that resident was under hospice services.

Facility owner stated on at 9:42 am that Resident #3 was admitted to the facility under hospice services but resident was able to feed herself and assist with transfer and with the rest on her activities of daily living but at this time the resident required total assistance with bathing, transfer, dressing, toileting, and ambulation but she is able to feed herself..

Resident #3 stated on at 10:10 am that she is able to feed herself but the she requires total help with her activities of daily living.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Peace Home Care, Inc
5040 Nw 197 Street
Miami, FL 33055

Dear Administrator:

This letter reports the findings of a Limited Nursing Services 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Ofice Manager

AMD:ve
Enclosure
XG90

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