STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911409	06/29/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
PROFESSIONAL HOME CARE II	447 EAST 31 STREET HIALEAH, FL 33013	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An Abbreviated Biennial Survey was conducted at on and concluded . Professional Home Care II with Limited Nursing Services component had the following deficiencies found at time of the 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 for the use of half bed rails for one of thirteen (#3) sampled residents.

Findings included:

On at 9:15 AM a half bed rail was observed attached to Resident #3's bed.

A record review of Resident #3's file was conducted. No evidence was located in Resident #3 file of a physician order for the use of half bed rails.

On at 12:02 PM an interview was conducted with the Administrator. The Administrator stated he was unable to locate the order for Resident #3's and would call the doctor to have him issue a current bed rail order.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview the assisted living facility failed to provide a record for the manager.

Findings included:

Record review found the Administrator supervised two facilities. Record review found the facility did not provide a record for the Manager.

Phone interview with the Administrator on revealed the facility has a Manager and the information would be faxed to the agency. As of , the agency has not received the fax.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

', 2015

Administrator
Professional Home Care Ii
447 East 31 Street
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a state 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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