STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968154	07/27/2015
NAME OF PROVIDER OR SUPPLIER **HEBERT INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1101 NW 26 AVENUE ROAD** **MIAMI, FL 33125**	

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

0000 Initial Comments

A Limited Nursing Services Monitoring was conducted on , 2015. Hebet Inc. with Limited Mental Health and Limited Nursing Services components had the following deficiency found at time of survey.

0030 Resident Care - Rights & Facility Procedures

Based on interview and record review, the Assisted Living Facility failed to have resident consent for the use of half-bed rails for two (#3 and #4) out of six sampled residents as well as to have a doctor order for the use of half-bed rails for one (#3) out of six sampled residents.

Findings included:

In an interview with Caregiver_A on at 9:52 AM revealed that Residents #3 and #4 used half-bed rails up while on bed.

Record review of Resident #3's file revealed that there was not doctor order for half-bed side rail neither resident consent for the use of half-bed rail.

Record review of Resident #4's file revealed that there was not resident consent for the use of half-bed rail.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Hebert Inc
1101 Nw 26 Avenue Road
Miami, FL 33125

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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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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