STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964722	**04/27/2016**
NAME OF PROVIDER OR SUPPLIER **LILI'S HOME CARE CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **6321 SW 20TH TERRACE MIAMI, FL 33155**	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on . Lili's Home Care Corp with Limited Mental Health component had deficiencies found at the time of the survey.

0008 Admissions - Health Assessment

Based on record review and interview the assisted living facility failed to have a completed health assessment for 1 out of 2 (Resident #1) sampled residents.

Findings include:

Record review found that Resident #1's health assessment dated did not indicate what type of assistance was required with medications.

On at 3:00 PM, the Administrator stated that the facility helps Resident #1 with her medications. She stated that she would have the doctor fix the health assessment.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and interview the facility failed to obtain a written physician's order for the use of two half-bed rails for one out of two (Resident #2) sampled residents.

Findings included:

Observation on at 9:50 AM showed that Resident #2 had two half bed rails attached to one side of her bed.

A review of Resident #2's file showed a physician's order for the use of a full bed rail.

On at 3:00 PM, the Administrator acknowledged the findings and she stated, "I'm going to call the physician".

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lili's Home Care Corp
6321 Sw 20th Terrace
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than ., 2016.** 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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