

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 03/20/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967452	(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER Millie Home Care	STREET ADDRESS, CITY, STATE, ZIP CODE 17810 Sw 137 Ct Miami, FL 33177	
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

An unannounced limited nursing services monitoring survey was conducted on . Millie Home Care
had deficiencies at the time of the survey.

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

Based on observation, record review and interview the Assisted Living Facility failed to obtain the written doctor order for the use of full-bed rail and resident's consent to use full-bed rail for 1 out of 1 sampled residents (#1).

Findings include:

1. Observation on . at approximately 8:50 a.m. revealed that on . # . resident #1 was lying on bed with full bed rail up.
2. Record review for resident #1's file revealed that there was no written doctor order for the use of full bed rail either a resident's consent to use full bed rail. There was a doctor order for half-bed rails dated .
3. On . at approximately 12:30 p.m. administrator acknowledged findings.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Millie Home Care
17810 Sw 137 Ct
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a state Limited Nursing Services (LNS) Monitoring survey that was conducted on , 2014 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 4/23/2014 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
Field Office Manager

AMD:sy
Enclosure
XG90

