PRINTED: 05/14/2014
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AC13930018	A. BUILDING: _____ B. WING _____	04/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVE OF KENDALL, INC	8603 S DIXIE HIGHWAY STE 102 MIAMI, FL 33143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS A relicensure survey was conducted on April 29, 2014 at Eve of Kendall 8603 S. Dixie Highway STE 102, Miami, FL, 33143. Eve of Kendall had deficiencies found at the time of the visit.	A 000	RECEIVED MAY 21 2014 AHCA HAQ-11 MIAMI	
A 156	Clinic Supplies/equip. Stand.-2nd Trimester Equipment Maintenance. (a) When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation, and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper calibration before returning it to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. (b) All anesthesia and surgical equipment shall have a written preventive maintenance program developed and implemented. Equipment shall be checked and tested in accordance with the manufacturer ' s specifications at designated intervals, not less than annually, to ensure proper operation and a state of good repair. (c) All surgical instruments shall have a written preventive maintenance program developed and implemented. Surgical instruments shall be cleaned and checked for function after use to ensure proper operation and a state of good repair. Chapter 59A-9.022(7), F.A.C.	A 156	CLINIC SUCTION WILL BE CHECKED ANNUALLY BY AN OUTSIDE MEDICAL EQUIPMENT COMPANY. CLINIC SUCTION MACHINES ARE REQUIRED TO HAVE INSPECTION STICKER WITH TIME, DATE, AND THE NAME OF COMPANY THAT PREFORMED INSPECTION. MOREOVER HOSES, TUBES HANDLES AND PRESSURES ARE CHECKED DAILY AND WILL BE LOGGED IN OUR MAINTENANCE BOOKS THAT NOW WILL INCLUDE DATE SUCTION MACHINE WAS CHECKED 5/19/14	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 — RLKP11 — If continuation sheet 1 of 2

* Revised

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AC13930016	A. BUILDING: _____ B. WING _____	04/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVE OF KENDALL, INC	8903 S DIXIE HIGHWAY STE 102 MIAMI, FL 33143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 156	Continued From page 1	A 156 →		

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to demonstrate an annual preventative maintenance inspection was performed in accordance with manufacturer's specifications at periodic intervals for the mechanical suction machine used in the procedure room.

The findings include:

A tour of the facility was conducted on 4/29/2014 beginning at 11:55 am. An observation of the mechanical suction machine revealed no inspection sticker.
An interview conducted on 4/29/2014 at 1:30 pm with Staff #1 revealed that it is not inspected annually by a maintenance technician. Staff #1 stated she was unable to locate the manufacturer's recommendations for routine maintenance of this machine.
A review of the last inspection invoice from the outside maintenance technician revealed the mechanical suction machine was not listed on the invoice.
A review of the facility's daily maintenance log for the suction machine confirmed the Ultrasound Technician is the person testing the machine daily.

COPY OF ACMI SUCTION MACHINE MODEL # VC-10 SERIAL NUMBER V05197O SHALL HAVE BERKELEY INSTRUCTION FOR USE + TECHNICAL MANUAL REVIEWED BY STAFF + DOCUMENTED AS PART OF OUR RECORDS FOR EQUIPMENT MAINTENANCE

PREVENTIVE IMPLEMENTED INSPECTION COMPLETED 5/19/2014

5/19/14

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 14, 2014

Administrator
Eve Of Kendall, Inc
8603 S Dixie Highway Ste 102
Miami, FL 33143

Dear Administrator:

This letter reports the findings of a State Re-licensure survey that was conducted on April 29, 2014 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten calendar days of receipt of this faxed report**. You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than May 29, 2014.**

The plan of correction must include the following:

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.

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. Should you have any questions please call Faith Randolph, Registered Nurse Consultant at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis
Field Office Manager, Area 11

Enclosure: State (3020) Form

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

IMPORTANT NOTICE – ACTION NECESSARY

POC NOT ACCEPTABLE/RECEIVED LETTER
May 20, 2014

Via facsimile to 305-668-5629

Eve Of Kendall, Inc
8603 S Dixie Highway Ste 102
Miami, FL 33143

RE: PLAN OF CORRECTION

Dear Administrator:
You were notified by our letter dated May 14, 2014 of deficiencies found at the April 29, 2014 survey of your facility. We requested you submit a plan of correction for the deficiencies cited within ten days of receipt of our notification letter. You were advised that the plan of correction must be acceptable in content and time frames.

We received your plan of correction on May 19, 2014. We have reviewed your submission and find that it is unacceptable for the following reasons:

Contains miscellaneous information and contractors names which will need to be removed

We are providing another opportunity for you to submit an acceptable plan of correction for the cited deficiencies. You must respond WITHIN 1 CALENDAR DAYS OF RECEIPT of this notice and provide a plan of correction that is acceptable in content and time frames.

If we do not receive an acceptable plan of correction WITHIN 1 CALENDAR DAYS from receipt of this notice, we will forward your case to the the Licensing Unit.

If you have questions regarding this letter, please contact me at 305-593-3100.

Sincerely,

Faith Randolph, RNC
Agency For Health Care Administration

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121