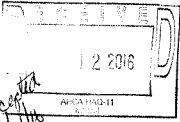


AGENCY FOR HEALTH CARE  
ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13930016</b>	(X3) DATE SURVEY COMPLETED  <b>03/24/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>EVE OF KENDALL, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8603 S DIXIE HIGHWAY STE 102 MIAMI, FL 33143</b>	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
<p><b>0000 INITIAL COMMENTS</b></p> <p>A Relicensure survey was conducted on _____, 2016. Eve of Kendall Inc had Licensure deficiencies found at the time of the visit.</p> <p><b>0153 Clinic Suppl/eat-2d Trimes-Resuscitative Meds</b></p> <p>Based on observation and interview, the facility failed to maintain a crash cart that was free from expired medication.</p> <p>Findings :</p> <p>Observation, conducted on _____, 2016 at 10:51 AM, of the facility's crash cart revealed that it contained Verapamil HCl medication that had an expiration date of 02/01/2016.</p> <p>On _____, 2016 at 10:51 AM, the _____ technician acknowledged the crash cart contained _____ HCl medication that had an expiration date of 02/01/2016.</p> <div style="text-align: center; margin-top: 20px;">  </div>		



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

January 15, 2016

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

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on January 15, 2016 by a representative 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 January 29, 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. Should you have any questions please call Faith Randolph, Registered Nurse Consultant at 305-593-3100.

Sincerely,

Arlene Mayo-Davis (for)  
Field Office Manager, Area 11

Enclosure: State (5000-3547) Form

XG90

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