

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRING OF LIFE ALF, INC

**11465 SW 57 STREET
MIAMI, FL 33173**

(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 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	A 078		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 078	Continued From page 1 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of an annual negative examination and a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable for one out of two sampled staff members (Staff B). Findings included: A review of Staff B's personnel records revealed Staff B was hired on and her last annual (. . .) examination was completed on Further review of Staff B's records	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 078	Continued From page 2 showed no documentation stating Staff B was free of any communicable On _____ at 8:51 AM, Staff B acknowledged her _____ screening had expired and stated that she would get a new one. Class III		A 078		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall		A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 084	Continued From page 3 include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____, _____, and _____ dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11667280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 084	Continued From page 4 i. Assist with _____; j. Use a _____ to perform _____ testing; k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____ levels; l. Apply and remove _____ stockings and hosiery; m. Placement and removal of _____ bags, excluding the removal of the _____ or manipulation of the _____ site; and, n. Measurement of _____ rate, temperature, and _____ rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff involved with the management of medications and assisting with the	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 084	Continued From page 5 self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse, a licensed pharmacist, or agency staff. The agency shall establish by rule the minimum requirements of this additional training. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure two out of two sampled staff completed a two hours annual update training prior to assisting with self-administration of medication (Staff A and B). Findings Included: On at 7:49 AM, Staff A was observed passing Resident#1 a medication cup with his café con leche without announcing the names to the resident. On at 7:50 AM, observed on the kitchen counter pre-poured medication cups labeled with the first letter of Resident# 3, 4, 5's name. On at 9:05 AM, observed Staff B take a labeled pre-poured medication from the kitchen counter. Staff B walked to Resident # 4's room and handed the resident medication cup. A review of Staff A's personnel records showed she was hired on and the last 2 hours' of Self - Administration of Medication training was conducted on . There was no evidence Staff A completed an annual continuing education training on providing assistance with self - administered medications.	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 084	Continued From page 6 A review of Staff B's personnel records showed she was hired on _____ and the last 6 hours' of Self - Administration of Medication training was conducted on _____. There was no evidence Staff A completed an annual continuing education training on providing assistance with self - administered medications. Class III	A 084			
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that Staff responsible for the facility's food service and the day-to-day supervision of food service staff obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility for one out of two sampled staff members (Staff A).	A 085			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 085	Continued From page 7 Findings Included: On at 7:08 AM, Staff A stated "I've been working here for 1 year. I work in the kitchen cooking and I help clean". On throughout the tour of the facility, observed Staff A in the kitchen preparing breakfast for all the residents. A review of Staff A's personnel records showed she was hired on and revealed an expired certificate of attendance of Nutrition and Food Service dated . Class III	A 085			
A 093 SS=G	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.frules.org/Gateway/reference.asp?No=Ref-04003 , and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf . Therapeutic diets must meet these nutritional standards to the extent possible.	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 093	Continued From page 8 (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 093	Continued From page 9 (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 093	Continued From page 10 stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a 3-day supply of non - perishable emergency foods meals consisted of the major 5 food groups for its census of 6 residents. The available nonperishable emergency food supplies were observed to be insufficient in quantity, and expired. The facility also failed to follow its menu. Findings Included: 1) According to the National Oceanic and Atmospheric Administration (NOAA), hurricane season "begins on _____ and lasts 5 months". The Agency for Healthcare Administration (AHCA) has issued guidance and clarification regarding hurricane preparedness plans to providers dated _____ notifying providers to "Ensure onsite supplies for sheltering in place for an extended period of at least 72 hours. It is essential to review your sheltering plans and secure sufficient amounts of food, water, and other necessary supplies to support your sheltering plans". According to the American _____ Association (AHA), it's suggested to have the following servings of each food groups:	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRING OF LIFE ALF, INC

**11465 SW 57 STREET
MIAMI, FL 33173**

(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 093	Continued From page 11 - Five servings per day of vegetables (fresh, frozen, canned and dried). - Four servings per day of fruits (fresh, frozen, canned and dried) - Six servings per day of grains (at least ½ should be whole grain/high in dietary) - Three servings per day of dairy (low-fat and fat-free) - Between eight to nine servings per week of poultry, meat, and eggs - Between two to three servings per week of fish and other seafood (preferably oily fish that provide omega-3 fatty acids) - Five servings per week of nuts, seeds, beans and legumes - Three servings per day of fats and oils (preferably unsaturated). On at 6:55 am, Staff A stated that the facility had a census of six residents. On at 7:27 AM, observed the facility's emergency food supply and found the following items: - 6 cans of tuna. Each can of tuna consisted of 2 servings; therefore, supplying a total of 24 servings. - 1 can of Fruit Cocktail. The can of Fruit Cocktail contained 24 servings of ½ cups. - 1 open box of Cream of Wheat, which holds a standard 24 servings when full, per container and each service size is 3 tablespoons. - 2 ½ packages of lady which consisted of 12 servings per package. - 3 bottles of Mott's Applesauce (expired) which consisted of approximately 11 servings each bottle. - 28 cans of Chicken Noodle Soup (expired on	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 093	Continued From page 12 ...) which consisted of approximately 10 servings with a serving size of ½ can. Further observation revealed expired food: - At least 10 individual bowls of assorted cereal (some were expired on ... and some were expired on ...). Each individual bowl consisted of 1 serving. - 4 cans of V8 vegetable juices (expired on ...) with a serving size of 1 can. - 1 can of mixed vegetable (expired on ...) with a serving size of 1 can. On ... at approximately 7:30 AM, the Administrator stated "It's expired? Then we bought it expired". 2) On ... at 7:49 AM, observed Staff A serve breakfast to Resident # 1 which consisted of two slice of toast with butter and a cup of coffee mixed with milk. A review of the facility's menu showed breakfast should have consisted of 4 oz. of Assorted Juices, ¾ cup of dry cereal or ½ cup of cooked cereal, 1 slice of bread, 1 tablespoon of butter, and 8 oz. of milk. On ... at 7:50 AM, Staff A stated "Not everyone eats cereal. Some do. That's why I don't serve it". Class II	A 093			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 162	Continued From page 13 (a) Resident demographic data as follows: 1. Name, 2. 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets,, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if	A 162			

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 162	Continued From page 15 a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an accurate	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRING OF LIFE ALF, INC

**11465 SW 57 STREET
MIAMI, FL 33173**

(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 162	Continued From page 16 and updated health assessment for one out of six sampled residents (Resident # 6) after a significant change. Findings Included: On at approximately 6:55 AM, Staff A stated that there were 6 residents in the facility and [Resident # 6] was under hospice care. On at approximately 9:30 AM, observed Resident # 6 being pushed on his wheelchair by a home health aide and was fed breakfast by Staff A. On at 12:34 PM, Staff B stated "[Resident # 6] doesn't walk. He can't transfer by himself. Normally we'll feed him, but he'll go for things he can grab on his own. He was evaluated for hospice, but his program decided to put him on Comfort Care on We put the medications in his most of the time". A review of Resident # 6's records showed an incomplete health assessment dated The section 'Physical or Sensory Limitations' on the health assessment was left blank. Further review of Resident # 6's health assessment showed Resident # 6 required assistance with Ambulation, Bathing, Self - Care (grooming), Toileting, Transferring and required Supervision with Eating. The health assessment also showed he needed assistance with self - administration of medication. There was no documentation stating Resident # 6 required total care in bathing, ambulation, eating, transferring and required medication administration.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 162	Continued From page 17	A 162		
A 163 SS=D	Class III 429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain resident records without alteration or falsification for three out of six sampled residents (Resident # 1, 3, and 4). Findings Included: On at 7:49 AM, observed Staff A pass a pre-poured medication cup to Resident # 1. A review of Resident # 1's Medication Observation Record (MOR) showed the following medications signed with Staff B's initials: 20 Mg daily, 75 Mg daily, 5 Mg daily, Tradjenta 5 Mg daily, 1,000, 250 250 Mg. On at 12:34 PM, Staff B confirmed that she was the one that signed the MOR's when she	A 163		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 163	Continued From page 18 pre poured the medication the night before. Class III	A 163			
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 19 emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F. S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 20 ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 21 period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval.	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 22 (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than _____, have implemented the plan required under this rule. (b) The Agency shall allow an extension up to _____ to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 23 extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 24 to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of . . . and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 25 safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 200	Continued From page 26 living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation that one out of six sampled residents, or the resident's representative, was notified about the Emergency Environmental Control for Assisted Living Facilities (ALF) (Resident # 3). Findings Included: A review of facility's records showed a Notification of Emergency Environmental Control for ALF dated _____ and signed by Resident # 1, 2, 4, 5, and 6. There was no documentation that showed Resident # 3 received the document. On _____ at 8:27 AM, Staff B stated that she would print an individual notification for each	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRING OF LIFE ALF, INC

**11465 SW 57 STREET
MIAMI, FL 33173**

(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 200	Continued From page 27 resident. Class III	A 200		
A 000	Initial Comments A complaint investigation (complaint number 2020009671) was conducted at Spring of Life, Inc. on _____ and concluded on _____. Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=G	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 010	Continued From page 28 department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care,	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 010	Continued From page 29 or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider; 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 010	Continued From page 30 living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview, observation, and record review, the facility failed to ensure the appropriateness of continued residency of one out of six sampled residents (Resident # 6). The resident, who was not under hospice care, could not walk or assist in his own transfer, and required medication administration. Findings Included: On _____ at approximately 6:55 AM, Staff A stated that there were 6 residents in the facility and [Resident # 6] was under hospice care. On _____ at approximately 9:30 AM, observed Resident # 6 being pushed on his wheelchair by a home health aide and was fed breakfast by Staff A. A review of Resident # 6's records showed he was admitted to the facility on _____ and the health assessment dated _____ showed the resident was diagnosed with _____, _____ () with _____, _____ () Ill with _____, _____ (), _____, _____, Right (R) Big _____, and (R) _____. On _____ at 12:34 PM, Staff B stated "[Resident # 6] doesn't walk. He can't transfer by himself.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 010	Continued From page 31 Normally we'll feed him. He was evaluated for hospice, but his program decided to put him on Comfort Care on We put the medications in his most of the time". Further review of the health assessment revealed Resident # 6 required Assistance with Ambulation, Bathing, Self - Care (grooming), Toileting, and Transferring. Resident # 6 also required supervision with eating and needed assistance with self - administration of medication. There was no documentation stating Resident # 6 was under hospice or comfort care, bedbound, and required medication administration. A review of Staff A's and B's personnel records showed neither was a licensed healthcare provider, able to administer medication. On at 1:44 PM, Resident # 6's healthcare provider from 'Comfort Care' stated "He enrolled with us in He was, had multiple He was able to transfer, he was able to walk, and he's just been declining for the past few months. He developed 's. We enrolled him in comfort care in due to his decline in function. We have an aide that goes every day to bathe and administer We expect for him to continue to deteriorate and currently has a expected to get worse. The is considered a as of today. We found the on Monday. On Monday it was a That required repositioning recommended every 2 hours. It's a He was declining in cognition and becoming more stiff". A review of Resident # 6's comfort care records	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 010	Continued From page 32 showed a note dated that stated "received report from nursing, new onset of to that was noted yesterday by ALF. Treatment: Teaching provided by nursing to reposition PRT every 2 hours". There was no documentation showing the facility repositioned Resident # 6 every 2 hours. Further review of Resident # 6's comfort care records showed a second note dated that had the following note: "Today noted with area of mild-moderate yellow to right side of, Size (cm): 2.0 cm x 3.0 cm x 0.2 cm to, Now classified as". On at 2:49 pm, Resident # 6's comfort care's nurse manager stated "we have to do a medical review with the Pace doctors and discuss further medical care plan for Resident # 6 and will see if he requires a higher level of care since he now has a". Class II	A 010			
A 030 SS=D	59A-36.007(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 33 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 34 of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity,	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 35 individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 36 and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, . . . , and	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 37 prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated _____ or _____ under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 38 dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to safeguard six out of six sampled residents' (Resident # 1 - 6) well-being by failing to follow current control standards related to COVID-19 and Florida Governor's emergency orders DEM Order 20-006, dated _____, delineating minimum screening standards for persons entering identified residential facilities. The facility also failed to honor the resident rights regarding the use of side rails for one out of six sampled residents (Resident # 2) Finding included: 1) The COVID-19 _____ is a transmissible _____ that presents a severe risk to persons who are aged, infirm, or suffer from co-_____ including, but not limited to, _____ system deficiency, _____, and _____. See generally, Publications of the Centers for _____ Control. On _____, the Governor of the State of Florida issued Executive Order 20-51, designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 39 Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most to the effects of . Among those emergency orders was DEM Order 20-006, dated, which mandated facilities to maintain documentation of all non-resident individuals screened using a standardized questionnaire or another form of documentation. It further stated that there must be documentation with the individual's name, date, and time of entry, the form used by the facility to screen the individual showing the individual did not meet any of the enumerated screening criteria, including the screening employee's printed name and signature. The Agency for Health Care Administration (AHCA) has issued guidance and clarification on DEM Order 20-006 to providers. On, issued an alert notifying Assisted Living Facility (ALF) that all staff or other individuals admitted to a residential facility must don masks and that caregivers must wear gloves when providing resident care. On at 6:55 AM, after ringing the facility's doorbell, Staff A opened the door and allowed surveyors to enter the facility. Observed that Staff A did not have a mask on. Staff A failed to verify the temperatures or complete a screening questionnaire for surveyors. Also observed a binder with screener sign in form and blank standardized questionnaires. Staff A then excused herself and left surveyors in the common area. When she returned to the room observed, Staff A was wearing a change of clothes and a mask.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 40 Record review showed COVID-19 questionnaires completed by health care workers visiting the facility for the dates to Interviewed on at 8:58 AM, Staff B stated that only medical professionals are allowed into the facility. Before entering the facility, the individual must have their PPE (Personal Protective Equipment) on. Staff then takes their temperature and ask the screening questions. The administrator further stated that all her staff is trained on the COVID-19 policies and procedures. Interviewed on at 9:43 AM, Staff B stated that Staff A told her that she had awakened when she heard the doorbell and was still groggy, so it slipped her mind to screen for COVID-19. 2) On at 7:10 AM, during a facility tour, observed a full bed rail installed in Resident # 2's bed in Interviewed on at 8:58 AM, Resident#2 stated that the bed rails were uncomfortable and hard to put down. Record review revealed that the facility has a referral, not a prescription from health care provider on file for the use of bed rails for Resident#2. Record review documented the facility failed to have Resident#2's consent for the use of full bed rails. Interview on at 8:29 AM, Staff B stated that Resident#1's medical provider told her that the bed rails were half not full. Staff B further asserted that Resident#1's medical provider told her that they no longer write prescriptions.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 030	Continued From page 41	A 030			
A 052 SS=D	Class III 429.256(. . .); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's . . . or placing the dosage in another container and helping the resident by lifting the container to his or her . . . (d) Applying . . . medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a . . . , including removing the cap of a . . . , opening the unit dose of . . . solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . . . (h) Using a . . . to perform . . . level checks. (i) Assisting with putting on and taking off . . . stockings.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 052	Continued From page 42 (j) Assisting with applying and removing an _____ but not with titrating the prescribed _____ settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with _____, bags. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) _____, or _____ preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 052	Continued From page 43 medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 052	Continued From page 44 prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record. 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's _____ control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow the correct procedures for assistance with self-administration of medication for three out of six	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 052	Continued From page 45 sampled residents (Residents#1, 3, 4) Findings include: On at 7:49 AM, Staff A was observed passing Resident#1 a medication cup with his café con leche without announcing the names to the resident. A review of the medication observation record (MOR) revealed that Staff A failed to initial that Resident#1 took his medication. The resident was given the following medications are to be taken at 8 AM: Famotidine 20 Mg daily, 75 Mg daily, 5 Mg daily, , Tradjenta 5 Mg daily, 1,000, 250 250 Mg. On at 7:50 AM, observed on the kitchen counter pre-poured medication cups labeled with the first letter of Resident# 3, 4, 5's name. On at 9:04 AM, observed Resident#3's B- Liquid and pre-poured medication cup beside Resident#3 while she was eating her breakfast on the kitchen counter. On at 9:05 AM, observed Staff B take a labeled pre-poured medication from the kitchen counter. Staff walked to Resident#4's room and handed the resident medication cup without reading the names aloud. Staff B then left the room without observing Resident#4 take the medication. Also observed that Staff B did not have the Medication Observation Record (MOR) with her while performing the task.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 052	Continued From page 46 A review of the MOR, revealed that Staff B failed to initial that Resident#4 took her medication. The resident was given the following medications are to be taken at 8 AM: 20 Mg daily, SOD daily, Potas 100 M daily, 1 Mg daily, SOD 100 Mg daily, 2.5 Mg daily, 5 Mg daily, ER 60 Mg. Interviewed on at 12:34 PM, Staff B stated that for her to be efficient, she pre-pours medication the night before she leaves the facility. Staff B further noted that before she bought the facility, the medications were a mess, so for control, she decided pre-pour medication and leave it for Staff A to pass out in the morning. Staff B also stated that she signs the MORs. Class III	A 052			
A 053 SS=G	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 053	Continued From page 47 for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including _____ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have licensed staff available to administer the medication for one out of six sample residents that required medication administration (Resident#6). Findings included: Record review showed that Resident #6 was admitted on _____. The health assessment dated _____ showed the resident was diagnosed with _____.	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 053	Continued From page 48 accident, major _____, right big _____dependent _____, type _____, and _____'s _____. Further review of the health assessment revealed that the resident was independent with eating and needed supervision with ambulation, bathing, _____, grooming, toileting, transferring, and needed assistance with self-administration of medication. On _____ at 9:43 AM, observed Staff A spoon-feed Resident#6 his breakfast. Reconciliation of medication for Resident #6 indicated that the medications given were _____ 81 mg tablet (used to reduce _____ and relieve mild to moderate _____), _____ 40 mg tablet (used to reduce the risk of _____ and _____), _____ 25-100 tablets, _____ 75 mg tablet (used to prevent _____ and _____ in persons with _____), _____ 20 mg tablet (used to treat damage from _____), _____, a condition in which backward flow of _____ from the _____ causes _____), _____ _____ 50 mg tablet, _____ 50 mg tablet, _____ 250 mg tablet and _____ 0.5 mg tablet (used to treat _____). According to the U.S. National Library of Medicine, - The combination of _____ and _____ is used to treat the symptoms of _____'s _____ and _____'s-like symptoms that may develop after _____ (_____ of the _____) or injury to the nervous system caused by monoxide _____ or manganese _____. If not appropriately taken, the resident may develop a severe _____ that causes _____, rigid _____, unusual body movements, and _____	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRING OF LIFE ALF, INC

**11465 SW 57 STREET
MIAMI, FL 33173**

(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 053	Continued From page 49 _____ tablets are used to treat the symptoms of _____ (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and inappropriate emotions). _____ tablets are also used to treat episodes of _____ (frenzied, abnormally excited or irritated _____). If not taken properly, the resident may experience an increase in their _____. The medication may also increase _____ and _____. _____ is used to treat _____, _____ (bothersome thoughts that won't go away and the need to perform specific actions over and over), and _____ (sudden, unexpected _____ of extreme fear and worry about these _____). If not taken properly, the resident may experience withdrawal symptoms such as _____, sweating, _____, irritability, _____, tiredness, _____, numbness, or tingling in the arms, _____, or _____. _____ is used to treat certain types of _____ is also used to treat (episodes of frenzied, abnormally excited _____) in people with _____ (_____, _____, a _____ that causes bouts of _____, episodes of _____, and other abnormal feelings). If not appropriately taken, the resident may experience irregular heartbeat or a loss of _____ for a period. Review of Staff A and Staff B's personnel record revealed that they both are not licensed medical professionals. Interviewed on _____ at 12:34 PM, Staff B stated that staff put medication in Resident#6's _____ because he can't put it in himself.	A 053		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 053	Continued From page 50 Interviewed on at 1:47 PM, Resident#5's healthcare provider from Comfort Care stated that Resident#6 needed medical administration. The provider further stated that she was aware that staff at the facility were not licensed medical professionals. A review of Resident # 6's comfort care records showed a note dated that had the following comments "Participant with no changes as he requires total assistance with all ADLs; therefore, ALF staff and aide from comfort care program assist with these tasks." Class II	A 053		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 054	Continued From page 51 number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical _____, the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to sign the medication observation records (MOR) during assistance with self-administration medications for six of six sampled residents immediately after the medications were given. The facility failed to ensure that the residents' MOR included the _____, the name of the resident's health care provider, and the health care provider's telephone number for one out of six sampled residents (Resident#3). Findings included: Review of MOR of Residents #1, #2, #3, #4, #5, and #6, revealed that staff did not initial the MOR for the morning medications for _____. The schedule on the MOR for the morning medications was at 8 AM. On _____ at 7:49 AM, Staff A was observed giving Resident#1's medication with along with his breakfast. On _____ at 9:04 AM, Staff B was observed handing Resident#4 her medication.	A 054			

If continuation sheet 53 of 58

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173		
(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 055	Continued From page 53 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued"	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173			
(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 055	Continued From page 54 medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medications were stored in a secure place that was out of sight of other residents. Findings included: On at 7:00 AM, during a facility tour, observed medication bottle with Resident#3's name on it on the kitchen counter. On at 7:20 AM, observed on one of the dressers in On at 7:50 AM, observed pre-poured	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OR SUPPLIER SPRING OF LIFE ALF, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 11465 SW 57 STREET MIAMI, FL 33173			
(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 055	Continued From page 55 medication cups on the kitchen counter. On at 9:43 AM, Staff B stated that Resident#3 becomes agitated when her bottle of medication is not there when she comes to the counter to eat her breakfast. Class II	A 055			