

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967313</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/30/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SERENE LIVING FACILITIES**

**8615 SW 43RD TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A COVID-19 control visit and generator survey was conducted at Serene Living Facilities on . Deficiencies were identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A 000               |                                                                                                                          |                          |
| A 078<br>SS=D            | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(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.<br>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 . . . . .<br>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 . . . . .<br>(b) Staff must be qualified to perform their | A 078               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967313</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/30/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SERENE LIVING FACILITIES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8615 SW 43RD TERRACE<br/>MIAMI, FL 33155</b>                                 |                          |                                                        |
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| A 078                                                               | <p>Continued From page 1</p> <p>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 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.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(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.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and interview, the facility failed to ensure that all Staff were able to exercise their responsibilities, consistent with their qualifications to perform their assigned duties consistent with their level of education, training, preparation, and experience in accordance with staff roles relating to emergency</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |

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| A 078                    | <p>Continued From page 2</p> <p>preparedness. The Staff on duty were unable to show their ability to start the alternate power source (the portable generator).</p> <p>Findings included</p> <p>Observation on ..... at 11:45 AM showed a portable generator (Wheelhouse 5550 Watts) in a shed in the backyard of the facility.</p> <p>On ..... at 11:46 AM, when asked Staff B to start the generator, Staff B stated that she could not start the generator and she would call the administrator for help. She also stated that Staff C was not available at the time to help her.</p> <p>On ..... at 11:50 AM, during a phone interview, The Administrator stated, "It is impossible for Staff B to start the generator. The Administrator stated, "I'm the administrator and I am the one who always start the generator."</p> <p>A review of the facility's emergency procedures, step 5 noted, "Based on the requirements established by Rule 58 A-5.036 a Staff Training must be conducted in order to effectively and immediately activate, operate, and maintain the alternate power source and any fuel required for the operation of the alternate power source. Facility will have a training manual specific to the individualized plans approved by local Office of Emergency Management."</p> <p>On ..... at 11:54 AM, the Administrator was informed of the facility emergency procedures and replied "oh ok, I understand now."</p> | A 078               |                                                                                                                          |                          |

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| A 078                                                               | Continued From page 3<br><br>Class III                                                                                       | A 078                                                                                    |                                                                                                                          |  |                                                        |