Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968367 | A. BUILDING: _____ B. WING _____ | 07/21/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING INC | 15560 NE 5TH CT MIAMI, FL 33162 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 000 | Initial Comments<br><br>A COVID-19 control and generator visit was conducted at Wellness Living, Inc.on . Deficiencies were identified at the time of survey. | A 000 | | |
| A 182 SS=D | 59A-36.019(3) FAC Emergency Mgmt - Plan Implementation<br><br>(3) PLAN IMPLEMENTATION.<br>(a) All staff must be trained in their duties and are responsible for implementing the emergency management plan.<br>(b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview the facility failed to ensure in the event of the loss of primary electrical power that all staff was trained in their duties and are responsible for implementing the emergency management plan. The facility staff was not able to gain access to the generator.<br><br>Findings included:<br><br>On at 11:30 AM, observed inside a shed a Predator 3500 Portable generator.<br><br>On at 11:30 AM, the Administrator stated she could not test the generator. She stated the generator was in the shed covered with items on top and she was not able to remove the generator.<br><br>Class III | A 182 | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE