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
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an updated employee roster within the background screening clearinghouse database for one out of four sampled staff members (Staff B). Findings Include:	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 On [redacted] at 8:51 AM, Staff C stated, "I've been working alone for the past month". At 12 PM, Staff C then stated, "the last day [Staff B] worked was on [redacted]". On [redacted] at 12:35 PM, the Administrator stated regarding Staff B, "Her last day working here was [redacted]". On [redacted] at 3:47 PM, a telephone interview with Staff B revealed that she had not worked at the facility for approximately six weeks because she had moved to another city. A review of the facility's background screening database showed Staff B was hired on [redacted] and showed no termination date. Unclassified	CZ814		

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A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 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;	A 055		

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A 055	Continued From page 1 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 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 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	A 055		

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A 055	Continued From page 2 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 keep medications in locked storage or in a locked storage area at all times. Findings Included: On at 8:56 AM and on at 2:51 PM, observation showed that the facility's medication cabinet was unlocked. Further observation on at 10:15 AM showed the medication cabinet with one cabinet door was ajar. On at 8:56 AM, Staff C stated, "Oh look, it opened". On at 2:51 PM, Staff C stated, "It's always locked". Observation on at 2:50 PM revealed # 's door wide open. Further observation showed Over-the-Counter (OTC) products placed on top of a TV dinner stand next to Resident # 9's bed; a bottle (1.5 FL Oz) of Spray; a small bottle (0.5 FL Oz) of sterile , and a small bottle of Spray. Class III	A 055		

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A 078	Continued From page 3	A 078		
A 078 SS=G	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	A 078		

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A 078	Continued From page 4 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. (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 observation, record review, and interview, the facility failed to prevent the entry of two staff members who did not have a medical clearance after testing positive for COVID-19 (Administrator and Staff D). Finding include: A review of records showed that the Administrator tested positive for COVID-19 on , . . , and . Staff A	A 078		

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A 078	Continued From page 5 tested negative for COVID-19 on [redacted]. the Administrator did not provide a medical clearance before entering the facility. A review of the records indicated that Staff D (co-owner) tested positive for COVID-19 on [redacted], [redacted] and [redacted]. Staff A did not provide a medical clearance for Staff D to enter the facility. There was no documentation of medical clearance at the site for Staff D, and there was no personnel file for him. On [redacted] at 9:54 AM, observation showed the Administrator entered the assisted living facility. On [redacted] at 12:00 PM, observation showed Staff D entered the assisted living facility. During a phone interview with the Administrator on [redacted] at 3:39 PM, she stated that "After testing positive for COVID-19, both Staff D and I [redacted] for 21 days. This was notified to my other employers since I also work as a hospice/home health nurse." Class II	A 078		
A 093 SS=D	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.flrules.org/Gateway/reference.asp?No	A 093		

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A 093	Continued From page 6 =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%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (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	A 093		

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A 093	Continued From page 7 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. (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	A 093		

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A 093	Continued From page 8 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 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 observations and staff interview, the facility failed post and followed a menu. The facility Also failed to have a 3 day emergency food supply to accommodate four out of 11 sampled residents (Residents #8, #9, #10, #11). Finding include: Observation of the facility kitchen at 9:00 AM on , showed that the facility menu for the day was not posted on the bulletin board. Further observation showed that the facility's 3 days Emergency food supply contained several food items that were expired: 1. One box of organic applesauce expired on . . . . . . 2. 10 meals ready to eat (MRE) Eversafe Meal Kit expired on . . 3. 8 cans of Garbanzo Beans (12 oz) expired on	A 093		

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A 093	Continued From page 9 4. 8 cans of Black Beans (15 oz) expired on In an interview on at 9:10 AM, Staff C stated "I guide myself by the menu, but the residents prefer soup. Yesterday, they had fish. The fish leftover will be served at noon. For dinner the residents will be served pork, soup, and potatoes." Class III	A 093		
A 160 SS=D	59A-36.015(1)(a-o)&(q-r) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to	A 160		

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A 160	Continued From page 10 which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for	A 160		

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A 160	Continued From page 11 food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local fire safety authority or the State Fire Marshal pursuant to Rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (q) The facility's prevention policies and procedures. (r) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated 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 up-to-date admission and discharge log. Three out of 11 sampled residents were not listed (Resident # 5, # 9, and # 11) and two residents did not have a discharge date (Resident # 4 and # 7). Findings Include: A review of the facility's admission and discharge	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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 160	Continued From page 12 log showed no documentation Resident # 5, # 9, and # 11 were ever admitted to the facility. On at approximately 8:55AM, observed Resident # 9 in her room. At 8:57 AM, Staff C stated regarding Resident # 9, "She just arrived 4 days ago". On at 4:05 PM, the Administrator stated in reference to Resident # 5, "She was admitted on . She was here for a few days because her family wanted to see if she would adapt to the ALF". On at 2:52 pm, observed Resident # 11 sitting in the living room. Staff C stated, "As of 2 or 3 days ago, [Resident # 11] came". Further review of the facility's admission and discharge log showed no documentation of the date and reason for discharge for Resident # 4 and # 7. Additionally, there was no documentation where both residents were discharged to. On at 1:35 PM, in reference to Resident # 7, the Administrator stated, "His legal guardian called me to tell me he no longer meets ALF criteria because he required 24-hour supervision". On at 2:40 PM, in reference to Resident # 4, the Administrator stated, "Last thing I know was that he , on ". Class III	A 160		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A 161	Continued From page 13 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A 161	Continued From page 14 (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity _____, to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a personnel record for one out of four sampled staff (Staff D). Findings Include: On _____ at 11:57 AM, observed Staff D enter the facility and sat in the living room. Further observation showed Resident # 9 was also sitting in the same living room. On _____ at approximately 10 AM, the Administrator stated, "[Staff D] doesn't work here. He is the [Vice President] of the ALF. Yes, he does maintenance of the facility and checks the generator". A review of facility records showed no personnel record for review for Staff D. A review of the facility's Background Screening Roster showed Staff D had a 'Controlling Interest with 5% or more interest". A review of Florida Health Finder showed Staff D was the co-owner of the facility.	A 161		

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A 161	Continued From page 15 Class III	A 161		
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) 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 resident's 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. Records of residents receiving nursing services from a third party must contain all orders for nursing services, all nursing assessments, and all nursing progress notes for services provided by the third party nursing services provider. Facilities that do not have such documentation but that can demonstrate that they have made a good faith effort to obtain such documentation may not be cited for violating this	A 162		

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A 162	Continued From page 16	A 162		

paragraph. A documented request for such missing documentation made by the facility administrator within the previous 30 days will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file.
(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)(f), F.A.C.
(f) A [illegible] 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 [illegible] 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 such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 162	Continued From page 17 to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is 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 a log listing the names of residents participating in this arrangement. (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	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 162	Continued From page 18 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 record review and interview, the facility failed to have a complete record for three out of 11 sampled residents (Resident # 5, # 9, and # 11). The facility did not have any documents indicating Resident's # 1, # 2, # 3, # 5, and # 6 at the facility, # 4 because of COVID-19, and that Resident # 7 in the facility more than once. The facility also failed to have Resident # 6's hospice records onsite. Findings Include: 1) Cross-reference citation 0025 - Resident Care - Supervision for further findings regarding Resident's # 1 and Resident # 7's repeated which had led to hospitalizations for sustaining a each time Resident # 7 Cross-reference citation 0030 - Resident Care - Rights & Facility Procedures for further findings regarding Resident's # 2, # 3, and # 5 deaths that occurred at the facility. Additionally, regarding Resident # 4's related to COVID-19. A review of Resident's # 1, # 2, # 3, # 5's records showed no documentation of them dying at the facility or received any kind of medical care prior to their deaths.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 162	Continued From page 19 A review of Resident # 7's records did not show any documentation he had at the facility and sustained two bleeds. On at 12:47 PM, when asked why there were no progress notes, the Administrator stated she did not have an answer explaining why. 2) On at approximately 8:55 AM, observed Resident # 9 in her room. At 8:57 AM, Staff C stated regarding Resident # 9, "She just arrived 4 days ago". A review of Resident # 9's records showed a yellow document with a list of Resident # 9's healthcare providers, a second list of names of medications and instructions, a copy of her driver license, a copy of her health insurance cards, and an outdated health assessment dated . There was no documentation of a demographic sheet, a resident contract, or any other documents to review. On at 4:05 PM, the Administrator stated regarding Resident # 5, "She was admitted on . She was here for a few days because her family wanted to see if she would accustom to the ALF". A review of Resident # 5's records showed a document that included a copy of insurance cards, social security card, and a copy of her passport. There were no other documents to review such as a health assessment, resident contract, a demographic sheet, and progress notes.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 162	Continued From page 20 On . . . . . at 2:52 pm, observed Resident # 11 sitting in the living room. Staff C stated, "As of 2 or 3 days ago, [Resident # 11] came. She sleeps in # with [Resident # 10]". A review of Resident # 11's records showed no documents other than a hospital admission and discharge summary, and medication documents. 3) A review of the facility's admission and discharge log showed Resident # 6 was admitted to the facility on and discharged on . The log also showed documentation that Resident # 6 was " " and ", , natural cause [sic]". On . . . . . at 12:59 PM, the Administrator stated, "Since we bought this ALF, she was under hospice. She was declining and her [Case Manager] came one day as a routine visit and noticed that she had labored breathing, she was eating less, she had a nurse that would come twice a day and they were monitoring her. She was placed under continuous care around or . . I don't have her hospice records. Hospice took them. She under continuous care". A review of Resident # 6's records showed no documentation Resident # 6 was placed on continuous care and , , . Further review of Resident # 6's records also showed no hospice records for review. Class III	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 21	A 165		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A 165	Continued From page 22 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A 165	Continued From page 23 through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report within one business day and within 15 days after the incidents to the Agency for Healthcare Administration (AHCA) for five out of 11 sampled residents who . . . or were injured onsite due to circumstances the facility could have been prevented (Resident # 1, # 2, # 3, # 5, and # 7). Findings Include:	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 24 Cross-reference citation 0025 - Resident Care - Supervision for further findings regarding Resident's # 1 and Resident # 7's repeated which led to hospitalizations for sustaining a . . twice when Resident # 7 . Cross-reference citation 0030 - Resident Care - Rights & Facility procedures regarding Resident's # 2, # 3, and # 5's deaths that occurred at the facility. A review of the facility's records showed no documentation of any of the 4 deaths that occurred in the facility and no documentation of Resident # 7's . A review of the online Adverse Incident Reporting System database showed no documentation the facility filed a one-day and a 15-day report to AHCA. On . . . . at 4:14 PM, the Administrator stated, "No, I didn't report it to AHCA because it was all natural causes and those that went to the hospital in the hospital and not at the ALF". Class III	A 165		
A1300 SS=D	Dem Emerg Order 2009 Visitation 1. Every facility must continue to prohibit the entry of any individual to the facility except in the following circumstances listed below within this Section. All facilities must require any individual who is entering the facility and who will have physical contact with any resident to wear PPE pursuant to the most recent CDC guidelines.	A1300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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
A1300	Continued From page 25	A1300		

Persons without physical contact with any resident must wear a mask.

A. Family members, friends, and individuals visiting residents in end of-life situations only;

B. Hospice or , care workers caring for residents in end-of-life situations;

C. Any individuals or providers giving necessary health care to a resident, provided that such individuals or providers (1) comply with the most recent Centers for Control and Prevention (CDC) requirements for PPE, (2) are screened for signs and symptoms of COVID-19 prior to entry, and (3) comply with the most recent control requirements of the CDC and the facility;

D. Facility staff;

E. Facility residents;

F. Attorneys of Record for a resident in an Adult Mental Health and Treatment Facility or forensic facility for court related matters if virtual or telephonic means are unavailable;

G. Public Guardians as set forth in chapter 744, Florida Statutes, Professional Guardians as defined by subsection 744.102(17), Florida Statutes and their professional staff pursuant to subsection 744.361(14), Florida Statutes;

H. Representatives of the federal or state government seeking entry as part of his or her official duties, including, but not limited to, Long-Term Care Ombudsman program, representatives of the Department of Children and Families, the Department of Health, the Department of Elderly Affairs, the Agency for Health Care Administration, the Agency for Persons with , a protection and advocacy organization under 42 U.S.C. §15041, the Office of the Attorney General, any law enforcement officer, and any emergency medical personnel;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A1300	Continued From page 26 l. Essential caregivers and compassionate care visitors who meet the following definitions and satisfy the following criteria: i. Essential caregivers are those who have been given consent by the resident or his or her representative to provide services and/or assistance with activities of daily living to help maintain or improve the quality of care or quality of life for a facility resident. Essential caregivers include persons who provided services before the pandemic and those who request to provide services. 1. Care or services provided by essential caregivers must be identified in the plan of care or service plan and may include bathing, , eating, and/or emotional support. ii. Compassionate care visitors provide emotional support to help a resident deal with a difficult transition or loss, upsetting event, or end-of-life. Compassionate care visitors may be allowed entry into facilities on a limited basis for these specific purposes. iii. Each resident or his or her representative may designate up to two (2) essential caregivers and up to two (2) compassionate care visitors. Other than in end-of-life situations, a resident may be visited by one (1) such visitor at a time; however, an intermediate care facility or Agency for Persons with . . . . licensed foster-care or group home facility may allow up to two (2) such visitors at a time. . Regarding essential caregivers and compassionate care visitors, the facility shall: 1. Establish policies and procedures for designation and utilizations of essential caregivers and compassionate care visitors. 2. Set a limit on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation.	A1300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1300	Continued From page 27 3. Develop an agreeable schedule in concert with the resident and visitor, including evening and weekends, to accommodate work or childcare barriers. 4. Provide . . . . prevention and control training, including training on proper use of personal protective equipment (PPE), . . . hygiene, and social distancing. 5. Designate key staff to support prevention and control training. 6. Screen general visitors to prevent possible introduction of COVID-19; 7. Maintain a visitor log for signing in and out. 8. Prohibit visits, except for compassionate care visits, if the resident is , ... or if the resident is positive for or shows symptoms of COVID-19. 9. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing. 10. After attempts to mitigate concerns, restrict or revoke visitation if the essential caregiver or compassionate care visitor fails to follow . . . . prevention and control requirements or other COVID-19-related rules of the facility. v. Essential caregivers and compassionate care visitors shall: 1. Wear a surgical mask and other PPE as appropriate. PPE for essential caregivers and compassionate care visitors must be consistent with the most recent CDC guidance for health care workers. 2. Participate in facility-provided training on prevention and control, use of PPE, use of masks, . . . sanitation, and social distancing, and sign acknowledgement of completion of training and adherence to the	A1300		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A1300	Continued From page 28 facility's . . . . prevention and control policies. 3. Comply with facility-provided COVID-19 testing, if offered; 4. Provide care or visit in the resident's room or in facility designated areas within the building. 5. Maintain social distance of at least six with staff and other residents and limit movement in the facility. vi. The facility may require essential caregivers and compassionate care visitors to submit to facility-provided COVID-19 testing so long as use of testing is based on the most recent CDC and U.S. Food and Drug Administration (FDA) guidance. J. General visitors, i.e. individuals other than essential caregivers or compassionate care visitors, under the criteria detailed below. i. To accept general visitors, the facility must meet the following criteria: 1. Other than in a dedicated wing or unit that accepts COVID-19 cases from the community, the facility must have no new facility-onset of resident COVID-19 cases in the previous fourteen (14) days; 2. The facility must have fourteen (14) days with no new facility-onset of staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test; 3. Sufficient staff to support management of visitors; 4. Adequate PPE for staff, at a minimum; 5. Adequate cleaning and . . . . supplies; and 6. Adequate capacity at referral hospitals for the facility. ii. General visitors must:	A1300		

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
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A1300	Continued From page 29 1. Be eighteen (18) years of age or older; 2. Wear a mask and perform proper hygiene; 3. Sign a consent form noting understanding of the facility's visitation and prevention and control policies; 4. Comply with facility-provided COVID-19 testing, if offered; 5. Visit in a resident's room or other facility-designated area; and 6. Maintain social distance of at least six with staff and residents, and limit movement in the facility. iii. Before allowing general visitors, the facility shall: 1. Prohibit visitation if the resident receiving general visitors is , , positive for COVID-19 and not recovered (as defined by most recent CDC guidance), or , , for COVID-19; 2. Screen general visitors to prevent possible introduction of COVID-19; 3. Establish limits on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation, including limits on the length of visits, days, hours and number of visits per week; 4. Schedule visitors by , , only; 5. Maintain a visitor log for signing in and out; 6. Immediately cease general visitation if a resident-other than in a dedicated wing or unit that accepts COVID-19 cases from the community-tests positive for COVID-19, or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19, or a staff person who was in the facility in the ten (10) days	A1300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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
A1300	Continued From page 30	A1300		

prior tests positive for COVID-19;

7. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing;

8. Notify and inform residents and their representatives of any changes in the facility's visitation policy;

9. Clean and visiting areas between visitors and maintain handwashing or sanitation stations; and

10. Designate staff to support -prevention and control education of visitors on use of PPE, use of masks, sanitation, and social distancing.

. Facilities allowing general visitation shall enable general visitation as described in either or both paragraphs 1 and 2 below:

1. Provide outdoor visitation spaces that are protected from weather elements, such as porches, courtyards, patios, or other covered areas that are protected from heat and sun, with cooling devices if needed.

2. Create indoor visitation spaces for residents in a room that is not accessible by other residents, or in the resident's private room if the resident is bedbound and for health reasons cannot leave his or her room.

v. Each resident or his or her representative may designate up to five (5) general visitors. A resident may be visited by no more than two (2) general visitors at a time.

vi. Each facility may require general visitors to submit to facility provided COVID-19 testing so long as use of testing is based on the most recent CDC and FDA guidance.

K. Barbers and beauty salons may resume services to residents with the following precautions:

i. Services are permissible only if:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A1300	Continued From page 31 1. Other than in a dedicated wing or unit that accepts COVID-19 cases, the facility has had no new facility onset of resident COVID-19 cases in the previous fourteen (14) days; and 2. Fourteen (14) days have passed with no new staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test. ii. Barbers and salon staff must wear surgical masks, gloves, practice hygiene, and follow the same requirements as essential caregivers; iii. Waiting customers must follow social distancing guidelines; . Residents receiving services must wear masks; v. Services are only provided to facility residents, not outside clients or guests; vi. Services may not be provided to a resident who tests positive for COVID-19 or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19; and vii. Service and salon areas must be properly cleaned and , and equipment must be sanitized between residents. 2. Individuals seeking entry to the facility, under the above section 1, will not be allowed to enter if they meet any of the screening criteria listed below: A. Any person with COVID-19 who does not meet the most recent criteria from the CDC to end , B. Any person showing, presenting signs or symptoms of, or disclosing the presence of a , including , , chills, , repeated shaking with chills, new loss of taste or smell, or any other COVID-19	A1300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A1300	Continued From page 32 symptoms identified by the CDC. C. Any person who has been in contact with any person(s) known to be with COVID-19, who does not meet the most recent criteria from the CDC to end isolation. 3. Residents leaving the facility temporarily for medical or other activities, and residents receiving visits from health care providers, must wear a mask, if tolerated by the resident's condition. All residents must be screened upon return to the facility. protection should also be encouraged. should be scheduled through the facility or group home to ensure proper screening and adherence to control measures. 4. All visitors must immediately inform the facility if they develop a or symptoms consistent with COVID-19, or test positive for COVID-19 within fourteen (14) days of a visit to the facility. 5. Documentation showing compliance with the following requirements must be kept for all visitation within a facility: A. Individuals entering a facility must be screened. To achieve this purpose, a facility may use a standardized questionnaire or other form of documentation. B. The facility is required to maintain documentation of all non-resident individuals entering the facility. The documentation must contain: i. Name of the individual entering the facility; ii. Date and time of entry; and iii. The screening mechanism used by the facility to conclude that the individual did not meet any of the enumerated screening criteria. This	A1300		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A1300	Continued From page 33 documentation must include the screening employee's printed name and signature. This Statute or Rule is not met as evidenced by: Based on observation and record review the facility failed to screen a visitor for COVID-19. Finding include: On at 10:10 AM, a family member of Resident #9 was observed entering the facility without been screened for COVID-19. Facility staff did not check his temperature, nor did he complete the COVID-19 questionnaire or sign the visitor log. The family member was wearing a facemask and proceeded to the dining table to talk to Resident #9. There was no social distancing between the two. A review of the facility screening record on at approximately 10:15 AM showed that the visitor was not screen by the facility staff. Class III	A1300		
A 000	Initial Comments A complaint investigation (complaint number 2020015285) in conjunction with a focused COVID-19 control monitoring and generator monitoring visit was conducted at Kevin's ALF Corp. on , and concluded on . Deficiencies were identified at the time of the visit.	A 000		
A 007 SS=G	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following	A 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A 007	Continued From page 34 minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as	A 007		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A 007	Continued From page 35 determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any ... or 4 , ... A resident requiring care of a , may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and, c. 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. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or f. Treatment of surgical or ,	A 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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 007	Continued From page 36	A 007		

unless the surgical or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record.
12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services:
a. and performed in the facility;
b. performed in the facility.
13. Not require 24-hour nursing supervision.
14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C.
15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on:
a. An assessment of the strengths, needs, and preferences of the individual;
b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available;
c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and,
d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule chapter 69A-40, F.A.C.
(b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable or assistance with routine care of site placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A 007	Continued From page 37 provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from . . . . . with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria. (e) Resident admission 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 observation, interview, and record review, the facility failed to ensure that one out of 11 sampled residents (Resident # 8) met the admission criteria. Resident # 8 was admitted to the facility with a Endoscopic . . . . . , (. . . .) tube. Findings Include: On . . . . . at 8:45 AM, Staff C, a caregiver, stated that the facility's census was three residents and one resident was under hospice care. On at approximately 8:50 AM, observed	A 007		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

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A 007	Continued From page 38 Resident # 8 in # laying on his bed. Staff C stated that Resident # 8 was under hospice care. On at 9:03 AM, Staff C stated, "He [Resident # 8] has a tube. We give him milk. The nurses come and give the milk and medications through the tube". A review of the facility's license on Florida Healthfinder revealed the facility was issued a standard license effective The facility was never issued a limited nursing services (LNS) or an extended congregate care (ECC) license. On at 9:31 AM, Staff C stated, "I am not a nurse". On at 12 PM, Staff C stated, "He [Resident # 8] arrived with a tube. He can walk with a walker. I sometimes assist him when he asks. The nurses come and gives him the milk". A review of the facility's admission and discharge log showed Resident # 8 was admitted on A review of Resident # 8's hospice records showed he was admitted to hospice on and diagnosed with . Further review revealed a narrative electronically signed by Resident # 8's hospice physician dated stating: "[Resident # 8] was hospitalized approx. 2 wks ago after suffering a catastrophic . He is presently being fed via , is increasingly weaker, more , sleeping more than before, he is mostly bed bound. At risk for , and ".	A 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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 007	Continued From page 39 According to the National [illegible] Institute, a [illegible] is "a tube inserted through the wall of the abdomen directly into the [illegible]. It allows air and fluid to leave the [illegible] and can be used to give drugs and liquids, including liquid food, to the patient". According to the American Society for [illegible] Endoscopy, some [illegible] complications include ", [illegible] at the [illegible] site, leakage of [illegible] contents around the tube site, and dislodgment or [illegible] of the tube. Possible complications include [illegible] of the [illegible] site, [illegible] (inhalation of [illegible] contents into the [illegible]), [illegible] and [illegible] (an unwanted hole in the [illegible] wall). A review of Resident # 8's health assessment dated on [illegible] showed he was diagnosed with: [illegible], Failure, [illegible] status. Resident # 8 required total care in ambulation, bathing, [illegible], eating, self-care (grooming), and required medication administration. The health assessment also showed that hospice was responsible for [illegible] three times a day and had documentation of "NPO" under the section titled 'Special Precautions'. According to Merriam-Webster, the medical definition of NPO is defined as "nothing by [illegible] ". On [illegible] at 12:07 PM, Resident # 8's Case Manager stated, "I was surprised that he [Resident # 8] had a [illegible] and was at an ALF. I went to see him the day before on the 15th and found out who had authorized for him to be there. I called the owner. He told me that the was given because [Resident # 8] originally went to the hospital for a [illegible] issue and four	A 007		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A 007	Continued From page 40 months later, they did a swallow test and then decided to put a . It was ordered to have 3 nurses daily for medication administration and feeding". Class II	A 007		
A 025 SS=L	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	A 025		

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A 025	Continued From page 41 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: B0025 - Resident Care - Supervision Based on interview and record review, the facility failed to provide care and services appropriate to the needs of two out of 11 sampled residents (Resident # 1 and # 7). Resident's # 1 was found to be unresponsive at the facility and did not receive any [redacted] ( ) from a staff member. Resident # 7 sustained a large acute [redacted] hematoma in the first incident, and a second hematoma in the second incident, after falling onsite. The facility also failed to keep any	A 025		

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A 025	Continued From page 42 documentation of the residents' deaths or . There were also no records documenting that resident's health care providers were contacted after significant changes. Findings Included: 1) A review of the facility's admission and discharge log showed Resident # 7 was admitted on and there was no documentation about his discharge. A review of Resident # 7's health assessment dated showed he was diagnosed with the following: , , Type 2, D Deficiency, , , Tardive Dyskinesia, and was alert and oriented times 2. He required supervision in eating and toileting and required assistance in bathing, , self-care, and self - administration of medication. During interview on at approximately 11:50 AM, when asked where Resident # 7 was the Administrator stated, "He's at rehab and will not be coming because the guardian told me he needed a higher level of care". On at 12 PM, Staff C (caregiver) stated, "He from the bed. He got tangled with the comforter and . When I ran to him, he had already . He had an injury to his . I cleaned his and placed him into bed. The next day, the bus from his program came and took him. I called the owners". Staff C did not provide the date of the incident. On at 1:35 PM, the Administrator stated	A 025		

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A 025	Continued From page 43 during an interview regarding the [redacted] incident with resident #7, "He's at [Rehab]. He belongs to [program]. He woke up in the middle of the night". The Administrator then stated, "[Staff C] heard a noise and went to see him. He had [redacted]. She asked him if he was okay. He was alert and oriented. In the morning, I called his doctor at [program] to come pick him up to do an [redacted] or CT (Computed [redacted]) Scan. I called his legal guardian. The [program] doctor called me and told me that he was going to be taken to the hospital because they didn't have an machine in the place he was at. This happened on [redacted] and his legal guardian called me to tell me he no longer meets ALF (Assisted Living Facility) criteria because he required 24-hour supervision". On [redacted] at approximately 1:40PM, the Administrator then stated regarding the [redacted] incident, "He has [redacted] two times. The first time he [redacted] was two months before. He was taken to the hospital and had surgery. It was on [redacted], during midnight hours. He ate breakfast the next day and I called [Program] and they came to pick him up and the doctor decided to send him to [hospital]. Supposedly he had a [redacted]. He went to a rehab and came [redacted] on [redacted], 2020. On [redacted] at 1:46 PM, Staff C stated, "It was in [redacted]. It was during midnight. [Staff B] and I were working. We were both in the living room sleeping. We heard that he [redacted] and we both went to help him. He [redacted] from the bed. We ran and picked him up and checked him and found he didn't have anything and laid him [redacted] on the bed and he went [redacted] to sleep".	A 025		

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A 025	Continued From page 44 A review of Resident # 7's records showed the last progress note was documented on . . . . . . There was no documentation of either or any documentation medical care was sought after Resident # 7 had . . . . both times. On at 2:33 PM, when asked what the facility had implemented to prevent Resident # 7 from falling again, the Administrator stated, "We monitored him for more hours. I did an , , with his doctor for a medication reconciliation". Interviewed on . . . . . at 11:08 AM, Resident # 7's legal guardian stated, regarding Resident # 7's unreported . . . , "He no longer lives there because of the investigation that I opened because I don't want him to return. He had two and they neglected to report to me, his [healthcare provider], and these . . ended up with a . . hematoma and had to have two surgeries. He was sent to [hospital]. The reason was because he coincidentally had to go to the program because I assume he had an , , and the Nurse Practitioner noticed his right side (. ., and arm) were dragging, he was weak, and she thought he had a . When he got sent to the hospital and they evaluated him, the hospital realized he had a . . . . . hematoma that accumulated. According to the Nurse Practitioner, it ended coming out that he had the . four days prior to the hospitalization". On at approximately 11:11 AM, Resident # 7's legal guardian then further stated, "According to my notes, [Resident # 7] arrived at the program on . . , ... , weak, . . . , ... and right and arm were dragging and couldn't move upper extremities. He was given an (, .) and it didn't make any	A 025		

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A 025	Continued From page 45 noticeable changes and transferred to [hospital]. I spoke to the department and he had a Hematoma. He had one surgery at [hospital] then discharged on to [Rehab] and returned to the ALF on ". The legal guardian then stated, "Apparently another resident that lived in the facility that attends [program] was positive for COVID-19. Because that resident was positive, [Resident # 7] was tested, and he tested positive as well. On , I was told of the result. When the results came in, [healthcare provider] immediately sent him to [hospital] for treatment and when he arrived to [hospital], he had a gash on his right from a . It was 2 ½ inches long and deep. What appears to have happened, my notes from [Nurse Practitioner], she had contacted the ALF to see if he . The Administrator told [Nurse Practitioner] that he at 9AM on . Nobody contacted me, not about COVID-19, not about the , nothing". On at 9:37 AM, Resident # 7's Nurse Practitioner stated, "He's had two at this ALF, and both had complications from it. The Administrator failed to notify [program]. On the 22nd, he came in to be seen in the clinic as a follow up. The staff continued to report the lack of appetite. When he was here, we noticed his upper right arm and right were very weak. At that moment, he was dragging his right and was sent to the Emergency Room (ER) and assumed it was an acute . We saw he had a hematoma. The ALF was contacted and asked if he had any injuries, any , anything unusual from the norms, and they denied everything. We told the ALF that he had a hematoma and they didn't say anything. We did ask them if he had a , they denied it. He was sent to the ALF on ".	A 025		

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A 025	Continued From page 46 In a continued interview on at approximately 9:45 AM, Resident # 7's Nurse Practitioner stated, "the following week, he was followed up post hospitalization and rehab and seen on the 18th. The next day on , we received a report from the ALF that this other resident was feeling bad and this resident was part of [program] and was tested on the 18th. Since they live together, we tested [Resident # 7] and on the 19th, he was tested for COVID-19 and then on the 20th, we received the report that he was positive. Since he was positive, we sent him to the COVID unit at [Rehab]. When he arrived at [Rehab], the nurse found a above the right . [Doctor] went to check up on him after I told her that he had again and due to the recent hematoma and hit on the , he went to [hospital]. He had another hematoma and stayed for observation. A review of Resident # 7's hospital records showed he was admitted to the hospital on and discharged on . Resident # 7's discharge summary had the following documentation: [Resident # 7] was hospitalized secondary to a hematoma and associated symptoms. Upon evaluation at the [Hospital] emergency department, he underwent imaging by way of a CT of the . That study showed evidence of a large hematoma. The neurosurgical service was consulted and recommended emergent surgical intervention". According to Harvard Medical School, "A hematoma occurs when a near the surface of the bursts. A hematoma is a life-threatening problem because it can compress the ".	A 025		

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A 025	Continued From page 47 An additional review of Resident # 7's hospital records showed he was admitted to the hospital a second time on and discharged on . A 'History & Physical Note' dated showed the following note: "He reportedly suffered another . A CT (Computerized) Scan revealed a new SDH (hematoma), thus he was admitted to the ( ). He is COVID+ (positive). According to the Mayo Clinic, a Computed (CT) Scan is a combination of images taken from different angles around the body which uses computer processing to create cross sectional images of tissues or bones. A review of the Florida Department of Children and Families (DCF) report regarding Resident # 7 revealed a 'Summary/Findings Implications' that showed: "Allegations of inadequate supervision present verified findings due to a preponderance of evidence. The VA (Adult) twice at the [ALF] resulting in hematomas. The facility failed to directly and promptly notify the VA's legal guardian on both occasions". 2) A review of the facility's admission and discharge log showed Resident # 1 was admitted to the facility on and discharged on . The log showed documentation that the reason for being discharged was due to 'Transfer to Hosp. ' and that Resident # 1 ' at Hospital'. A review of Resident # 1's hospital records showed Resident # 1 was admitted on with a diagnosis of " ". Records also	A 025		

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A 025	Continued From page 48	A 025		

showed that Resident # 1 [illegible] on [illegible] at 10:47 AM. The preliminary cause of [illegible] was Multiorgan Failure and Hypoxic [illegible]. Furthermore, Resident # 1's discharge diagnosis showed the following: "[illegible], Multiorgan Failure, COVID PNA ([illegible]) and AKI (Acute [illegible] Injury)".

A review of fire rescue's ambulance run record regarding Resident # 1 showed Emergency Medical Services ([illegible]) arrived at the facility on [illegible]. The record revealed the chief complaint was "[illegible]". The record also revealed the following narrative: "ALF caretaker states that she heard the [illegible] (patient) [illegible] after getting out of shower. Upon arrival, [illegible] was lying in hallway just outside of bathroom. [illegible] was found lying on [illegible] in full [illegible] ([illegible]). [illegible] and Advanced Life Support ([illegible]) procedures were initiated and [illegible] was transported to [hospital]".

Further review of the run record showed that Resident # 1 had a [illegible] before Emergency Medical Services ([illegible]) had arrived at the facility. It stated no [illegible] was provided before their arrival. The record also stated: "Patient MEETS Suspected COVID-19 criteria".

A review of Resident # 1's [illegible] report dated [illegible] revealed: "Impression: Multifocal airspace and [illegible] opacities throughout the [illegible], likely representing multifocal [illegible]".

According to MedicineNet, the term multifocal is defined as "having to do with two or more foci (a central point) or arising from two or more places".

According to the National [illegible], [illegible], and [illegible] Institute, "[illegible] is an [illegible] that affects

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A 025	Continued From page 49 one or both [illegible]. It causes the air [illegible], or alveoli, of the [illegible] to fill up with fluid or pus". A review of the facility's records showed no documentation that Resident # 1 had [illegible], was [illegible], or suffered a [illegible] at the facility. During an interview on [illegible] at 12 PM, Staff C stated, "With [Resident # 1], I wasn't working. [Staff B] was working. She was working alone. What I heard was that he always had big [illegible] and would [illegible]. Sometimes he would do a lot of [feces] when he would be [illegible]. He would be [illegible]; we would give aerosol. He hasn't [illegible] and has no history of falling". On [illegible] at 1:05 PM, the Administrator stated regarding Resident # 1, "He had [[illegible]], normally he would be [illegible]. It was a condition he already had. The night of [illegible], he laid down at midnight and woke up to go to the bathroom. [Staff B] felt some type of movement and went to go see him. He stated that he wasn't feeling well and [Staff B] called rescue. Patient was alert, but with a lot of [illegible]. Rescue came and took vital signs and did the [illegible] and decided to take him to the closest hospital. This was around 3:30, 3:45 in the morning. He doesn't have family. He has a friend. We called [Friend]. He never picked up. We left him a message". A review of the Florida Department of Health's report revealed Resident # 1 tested positive for COVID-19, the same day he [illegible] on [illegible]. On [illegible] at 1:35 PM, the Administrator stated regarding the facility, "To my knowledge, no one	A 025		

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A 025	Continued From page 50 had COVID-19". On at 3:03 PM, the Administrator stated regarding Resident # 1, "The employee noticed he was out of breath. She was alone working. [Staff B] called me the moment it happened". The Administrator then revealed a text message on her cellular phone that showed a message in Spanish which [Staff B] had sent the Administrator at 3:31 AM on : "[Resident # 1] esta ahora con mucha falte de aire. Y se cayo en el suelo. Tuve q llamar a novio para q lo . Esto esta muy mal". In English, the message is translated to: [Resident # 1] is very . And on the floor. I had to call my boyfriend to lift him up. This is so wrong". On at approximately 3:07 PM, the Administrator stated regarding the text message, "She texted me and I called her to ask what happened. She stated that he got up from bed to the bathroom. He didn't . I wasn't here. I'm only telling you what they told me. She told me that she heard a noise and when she went to the bathroom, she saw that his was in front of the bathroom sink. She called rescue. Rescue came. [Staff B] took him to the room". On at 3:11 PM, when the Administrator was asked why Resident # 1 became unresponsive and no was provided, she stated "The son told me that he in the hospital. I contacted the hospital and they told me that he at the hospital". A review of Resident # 1's health assessment dated showed diagnoses of: Non- , , High , Atherosclerotic , , , and . Resident # 1 also had decreased	A 025		

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A 025	Continued From page 51 vision, hearing, memory, and concentration. He required supervision in bathing, , self-care (grooming), and toileting and needed assistance with transferring and self-administration of medication. Further review of Resident # 1's records showed the last progress note on file was dated . There was no documentation of the residents' , , , and/or . There was also no documentation that Resident # 1's family members, friend, or healthcare provider were contacted. Additionally, there was no documentation of a ( ). On at 10:44 AM, an interview with Resident # 1's family member revealed, "A week ago, [Administrator] mentioned that my grandfather's roommate also got sick and was hospitalized and . She mentioned that it was COVID-19". On at 11:44 AM, Resident # 1's family member stated regarding their conversation with the Administrator, "When I spoke to her the first time, she ensured that it wasn't COVID-19. She said, "In the facility we don't have COVID-19". She didn't even call me when he . My aunt went to the facility in to visit [Resident # 1] and wanted to confirm that the new owners had the correct contact information. We found out he on . She said that she called [Resident # 1's friend], but [Resident # 1's friend] never received a call. [Resident # 1's friend] didn't even know until I told him. She lies to me about everything. When we received all the documents (medical records), we found out the truth".	A 025		

Agency for Health Care Administration

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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KEVIN'S ALF CORP	5111 SW 112 AVE MIAMI, FL 33165

(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 025	Continued From page 52 Class I	A 025		
A 027 SS=L	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , , , , , , , , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to facilitate and arrange access to health care services for three out of 11 sampled residents (Resident # 4, # 5, and # 7). Resident # 4 spent 3 days coughing without any medical care until he was hospitalized and , , , because of COVID-19. Resident # 5 received no medical care until her family member brought Resident # 5 coughing medications. Resident # 7 sustained a large acute , , , , , , , hematoma in the first incident, and a second hematoma in the second incident, after falling onsite. Resident # 7's healthcare providers were not aware of either of the , , and transported him to the hospital for secondary reasons.	A 027		

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A 027	Continued From page 53 Findings Include: 1) A review of Resident # 4's records showed he was admitted to the facility on [redacted] and a health assessment dated [redacted]. The health assessment showed he was diagnosed with [redacted], Type 2 [redacted], Intellectual [redacted], and [redacted]. A review of Resident # 4's hospital records revealed a discharge summary that showed Resident # 4 was brought to the Emergency Department via [redacted] (Emergency Medical Services) from the [ALF] on [redacted] with a complaint of [redacted] and [redacted] that started 2 days prior. The hospital records showed that Resident # 4 arrived at the Emergency Department with a [redacted] and tachycardic and was admitted for the following diagnosis: Acute Hypoxemic [redacted] Failure, and COVID-19. Further review of hospital records revealed Resident # 4 was tested positive for COVID-19 on [redacted]. They also showed he [redacted] on [redacted] at 3:35 AM due to Severe Acute [redacted] Distress [redacted] related to COVID-19 and Multiple Organ [redacted]. The discharge summary also revealed a preliminary cause of [redacted] related to [redacted] and Acidosis. A review of fire rescue's ambulance records dated on [redacted] showed the primary impression was Acute [redacted] Distress. The run record also showed Resident # 4's [redacted] Oximetry was at 84% at Room Air. Further review of the run record revealed the following documentation: "Meets Suspected COVID-19 criteria" and	A 027		

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A 027	Continued From page 54 showed the following narrative: "patient coughing and experiencing low , saturation. Resident was transported to [hospital]". On at 12 PM, Staff C (caregiver) stated regarding Resident # 4, "He was sent to the hospital because he had . In the morning, [Staff B] touched his and felt it hot. She took his temperature and we called the administrator. The owners came and called 911. In the hospital, he had a ". Staff C did not provide a date this incident occurred. On at 2:40 PM, the Administrator stated regarding Resident # 4, "He had a daily nurse because he was . In her reports, the patient didn't have or , but I started to notice on Friday ( ) that he was coughing. On Monday ( ), I spoke to the nurse to request for her to speak to the doctor to have something prescribed for the . [Healthcare Provider] came to do an , that Monday, the 17th of . On , I came to the [ALF] and I called the doctor and she didn't have the results yet and the doctor and I decided that it was best to call rescue to have him transported to the hospital. The doctor was going to prescribe , but they were going to arrive later at night at around 11 pm. He went to the [hospital] on Tuesday . Last thing I know was that he on ". A review of Resident # 7's records showed no documentation that a medical provider was contacted when the Administrator noticed Resident # 7 had a on . There was no documentation that there was a log that reported Resident # 7's symptoms such as coughing and for the 3 days.	A 027		

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A 027	Continued From page 55 Further review of Resident # 7's records showed no documentation from the nurse that would go and administer to Resident # 7. On at 9:37 AM, Resident # 4's healthcare provider stated, "I ordered the , in the afternoon ( ) and it was done on the 18th, in the morning. That same day, the COVID-19 test was ordered. The same day, the nurse reported that he continued with the in the morning but wasn't with at that time. That afternoon I received a call from the [ALF] saying that he's and wasn't feeling too good. He had no but had a . I called to the [ALF] to try to speak to the patient and they put him on the speaker, he couldn't speak, and I was able to hear the and told them that they had to call 911 now. At the [Emergency Room], he was diagnosed with COVID-19 and multifocal . He was admitted and transferred to [ ] on Saturday, . They had to intubate him because he required more . The cause of was Hypoxic , Failure in the setting of COVID-19 and Severe . He went into severe , distress and then on , pronounced at 3:35 AM". 2) On at 9:33 AM, when asked how to perform , Staff C stated, "I call 911 and they count for me. They don't count a lot. I've done it before to [Resident # 5]." A review of the facility's admission and discharge log showed no documentation Resident # 5 had ever been admitted to the facility.	A 027		

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A 027	Continued From page 56	A 027		

A review of Resident # 5's records showed no documentation of a health assessment, a resident contract, or progress notes.

On at 9:36 AM, Staff C stated regarding Resident # 5, [Resident # 5] was only here for a few days. She had ; she had a . She wasn't breathing normal, so I called 911 then started . She did have a

On at 12 PM, Staff C then stated regarding Resident # 5, "I put her to bed at approximately 1 AM and saw her breathing very bad. I called 911. 911 told me to do . She was still breathing, and she had a very slow ".

On at 4:05 PM, the Administrator stated regarding Resident # 5, "She was admitted on . She was here for a few days because her family wanted to see if she would get accustomed to the ALF. [Staff C] was working. [Staff C] called me and told me that she had woken up and [Resident # 5] would usually scream at night and [Staff C] went to check on her because she wasn't screaming that night. She called me and told me that she didn't see [Resident # 5] well and I told her to call rescue. Rescue came and declared her ".

A review of fire rescue's ambulance run record for Resident # 5 showed arrived at the facility on . The record showed a primary impression documented as " Upon Arrival". The record also said: "Upon arrival, R-41 (Rescue 41) found a non-viable patient in an [ALF] laying alongside her bed unresponsive with a GCS (Glasgow Scale) of 3. Absent . No , , and livor

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A 027	Continued From page 57 mortis all present. Pupils fixed and non- reactive. Scene was released to [police department]". According to the Center of Control and Prevention (CDC), "Livor Mortis is the setting of to the dependent parts of the body in accordance with gravity once circulation of the has ceased. The onset of livor mortis is immediate, perhaps beginning even before the time of ; it is well manifested in two to four hours and is at its maximum or "fixed" level in 8 to 12 hours". On at 3:05 PM, Resident # 5's family member stated, "She told me she was coughing a lot. I went directly to [medical provider] and called the doctor and she prescribed medications. I arrived at the facility with a ِ syrup and medications. I told them that if she continues to ِ to call rescue. She on and I had gone on . . . . . The Administrator would tell me that she would spend the nights screaming and told me that she would call a psychiatrist". On . . . . . at 4:20 PM, during a phone interview, Resident # 5's Primary Care Physician (PCP) stated, "I gave her . . . . . and tiotropium and a ِ syrup. She was in the hospital from . , ... to ِ . . . . . She went in for , . . . and was given . I last spoke with [family member] on ِ . . . . because they called me because she was coughing a lot". Further review of Resident # 5's records showed no documentation Resident # 5 was screaming at night, coughing, or receiving any kind of medical care prior to passing away. 3}	A 027		

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A 027	Continued From page 58 A review of the facility's admission and discharge log showed Resident # 7 was admitted on [redacted] and there was no documentation about his discharge. A review of Resident # 7's health assessment dated [redacted] and showed he was diagnosed with the following: [redacted] Type 2, [redacted] D Deficiency, [redacted] Tardive Dyskinesia, [redacted] and was alert and oriented times 2. He required supervision in eating and toileting and required assistance in bathing, [redacted] self-care, and self - administration of medication. On [redacted] at approximately 11:50 AM, when asked where Resident # 7 was, the Administrator stated, "He's at rehab and will not be coming [redacted] because the guardian told me he needed a higher level of care". On [redacted] at 12 PM, Staff C (caregiver) stated, "He [redacted] from the bed. He got tangled with the comforter and [redacted]. When I ran to him, he had already [redacted]. He had an injury to his [redacted]. I cleaned his [redacted] and placed him [redacted] into bed. The next day, the bus from his program came and took him. I called the owners". Staff C did not provide the date of the incident. On [redacted] at 1:35 PM, the Administrator stated regarding the [redacted] incident, "He's at [Rehab]. He belongs to [program]. He woke up in the middle of the night". The Administrator then stated, "[Staff C] heard a noise and went to see him. He had [redacted]. She asked him if he was okay. He was alert and oriented. In the morning, I called his doctor at [program] to come pick him	A 027		

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A 027	Continued From page 59 up to do an or . I called his legal guardian. The [program] doctor called me and told me that he was going to be taken to the hospital because they didn't have an machine in the place he was at. This happened on and his legal guardian called me to tell me he no longer meets ALF criteria because he required 24-hour supervision". On at approximately 1:40 PM, the Administrator then stated regarding the incident, "He has two times. The first time he was two months before. He was taken to the hospital and had surgery. It was on , during midnight hours. He ate breakfast the next day and I called [Program] and they came to pick him up and the doctor decided to send him to [hospital]. Supposedly he had a . He went to a rehab and came on th. On at 1:46 PM, Staff C stated, "It was in . It was during midnight. [Staff B] and I were working. We were both in the living room sleeping. We heard that he and we both went to help him. He from the bed. We ran and picked him up and checked him and found he didn't have anything and laid him on the bed and he went to sleep". A review of Resident # 7's records showed the last progress note was documented on . There was no documentation of either or any documentation medical care was sought after Resident # 7 had both times. On at 2:33 PM, when asked what the facility had implemented to prevent Resident # 7 from falling again, the Administrator stated, "We monitored him for more hours. I did an with his doctor for a medication reconciliation".	A 027		

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A 027	Continued From page 60 On at 11:08 AM, Resident # 7's legal guardian stated regarding why Resident # 7's unreported , "He no longer lives there because of the investigation that I opened because I don't want him to return. He had two and they neglected to report to me, his [healthcare provider], and these ended up with a hematoma and had to have two surgeries. He was sent to [hospital]. The reason was because he coincidentally had to go to the program because I assume he had an and the Nurse Practitioner noticed his right side (and arm) were dragging, he was weak, and she though he had a . When he got sent to the hospital and they evaluated him, the hospital realized he had a hematoma that accumulated. According to the Nurse Practitioner, it ended coming out that he had the four days prior to the hospitalization". On at approximately 11:11 AM, Resident # 7's legal guardian then further stated "According to my notes, [Resident # 7] arrived at the program on , weak, , and right and arm were dragging and couldn't move upper extremities. He was given an (,) and it didn't make any noticeable changes and transferred to [hospital]. I spoke to the department and he had a Hematoma. He had one surgery at [hospital] then discharged on to [Rehab] and returned to the ALF on ". The legal guardian then stated, "Apparently another resident that lived in the facility that attends [program] was positive for COVID-19. Because that resident was positive, [Resident # 7] was tested, and he tested positive as well. On , I was told of the result. When the results	A 027		

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A 027	Continued From page 61	A 027		

came in, [healthcare provider] immediately sent him to [hospital] for treatment and when he arrived to [hospital], he had a gash on his right ¿ from a . It was 2 ½ inches long and deep. What appears to have happened, my notes from [Nurse Practitioner], she had contacted the ALF to see if he . The Administrator told [Nurse Practitioner] that he at 9 AM on ¿ . Nobody contacted me, not about COVID-19, not about the , nothing".

On at 9:37 AM, Resident # 7's Nurse Practitioner stated, "He's had two at this ALF, and both had complications from it. The Administrator failed to notify [program]. On the 22nd, he came in to be seen in the clinic as a follow up. The staff continued to report the lack of appetite. When he was here, we noticed his upper right arm and right ¿ were very weak. At that moment, he was dragging his right and was sent to the Emergency Room (ER) and assumed it was an acute . We saw he had a hematoma. The ALF was contacted and asked if he had any injuries, any , anything unusual from the norms, and they denied everything. We told the ALF that he had a hematoma and they didn't say anything. We did ask them if he had a , they denied it. He was sent to the ALF on ¿ ".

In a continued interview on at approximately 9:45 AM, Resident # 7's Nurse Practitioner stated, "the following week, he was followed up post hospitalization and rehab and seen on the 18th. The next day on ¿ , we received a report from the ALF that this other resident was feeling bad and this resident was part of [program] and was tested on the 18th. Since they live together, we tested [Resident # 7] and on the 19th, he was tested for COVID-19 and

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A 027	Continued From page 62 then on the 20th, we received the report . . . that he was positive. Since he was positive, we sent him to the COVID unit at [Rehab]. We he arrived at [Rehab], the nurse found a above the right , ... [Doctor] went to check up on him after I told her that he had again and due to the recent . . . . . hematoma and hit on the , he went to [hospital]. He had another . . . . . hematoma and stayed for observation. A review of Resident # 7's hospital records showed he was admitted to the hospital on . . . . . and discharged on . . . . . Resident # 7's discharge summary had the following documentation: [Resident # 7] was hospitalized secondary to a hematoma and associated symptoms. Upon evaluation at the [Hospital] emergency department, he underwent imaging by way of a CT of the . . . That study showed evidence of a large . . hematoma. The neurosurgical service was consulted and recommended emergent surgical intervention". According to Harvard Medical School, "A hematoma occurs when a . . . . . near the surface of the bursts. A hematoma is a life-threatening problem because it can compress the ". An additional review of Resident # 7's hospital records showed he was admitted to the hospital a second time on and discharged on . . . . . A 'History & Physical Note' showed the following note: "He reportedly suffered another . . . A CT (Computerized . . . . . } Scan revealed a new SDH (. . hematoma), thus he was admitted to the . . (. . . . .). He is COVID+ (positive). According to Mayo Clinic, a Computed	A 027		

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A 027	Continued From page 63 (CT) Scan is a combination of images taken from different angles around the body which uses computer processing to create cross sectional images of tissues or bones. A review of the Florida Department of Children and Families (DCF) report regarding Resident # 7 revealed a 'Summary/Findings Implications' that showed: "Allegations of inadequate supervision present verified findings due to a preponderance of evidence. The VA (Adult) twice at the [ALF] resulting in hematomas. The facility failed to directly and promptly notify the VA's legal guardian on both occasions". Class I	A 027		
A 030 SS=L	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 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	A 030		

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A 030	Continued From page 64 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; [illegible], 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-[illegible] 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 [illegible], neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. [illegible] control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery 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	A 030		

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(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 65 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, 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	A 030		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A 030	Continued From page 66 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 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.	A 030		

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A 030	Continued From page 67 (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 [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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 [illegible], 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, [illegible], and 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	A 030		

Agency for Health Care Administration

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A 030	Continued From page 68 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 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	A 030		

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A 030	Continued From page 69 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 interview and record review, the facility failed to treat four out of 11 sampled residents with respect, due recognition of personal dignity, free of neglect (Residents # 1, 2, 3, and # 5). Residents # 1, 2, 3 and 5 were found unresponsive at the facility and subsequently . Facility staff who found Residents # 1, and # 3 unresponsive, did not perform ( ). Resident #1's family was not notified of his until nine days later. Resident # 2, who did not wish to be , did not have her wishes honored because her ( ) was not provided to emergency responders, who performed on the resident. Resident #2 was not provided with medical care until an hour after she was found ' and pale'. The facility also failed to screen visitors for COVID-19, and staff who had tested positive for the entered the site without a medical provider's certification that they were no longer at risk of transmitting the . Findings Include: 1) A review of the admission/discharge log showed that Resident #1 moved in on from his family's home, was transferred to the hospital on and was discharged on . The log showed that the resident ', at the hospital'. A review of facility records showed that no reports were filed with the Agency for Health Care Administration (AHCA) regarding Resident #1's	A 030		

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A 030	Continued From page 70 A review of Resident # 1's health assessment dated showed he was diagnosed with: Non- , High , Atherosclerotic , and . He also had decreased vision, hearing, memory, and concentration. Resident #1 required assistance in the following Activities of Daily Living (ADL): bathing, , grooming, toileting, transferring, and self-administration of medications. A review of Resident # 1's hospital record and discharge summary dated revealed Resident #1 was admitted to the hospital due to a . The discharge diagnoses were: , Multiorgan failure, COVID , and Acute Injury. The preliminary causes of were Multiorgan Failure and Hypoxic . The record reflected Resident #1 tested positive for COVID-19 on , on arrival at the hospital. Further review of Resident # 1's hospital records showed that he on at 10:47 AM. On at 3:03 PM, the Administrator stated regarding Resident # 1, "The employee noticed he was out of breath. She was alone working. [Staff B] called me the moment it happened". The Administrator then revealed a text message on her cellular phone that showed a message in Spanish which [Staff B] had sent the Administrator at 3:31 AM on : "[Resident # 1] esta ahora con mucha falte de aire. Y se cayo en el suelo. Tuve q llamar a novio para q lo . Esto esta muy mal". In English, the message is translated to: [Resident # 1] is very	A 030		

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A 030	Continued From page 71 . . . . And . . on the floor. I had to call my boyfriend to lift him up. This is so wrong". A review of the fire rescue ambulance run record dated regarding Resident # 1 showed that the service was dispatched at 3:58 AM, 55 minutes after Staff found him on the floor. Emergency Medical Services (. . .) arrived at the facility on 4:03 AM. The record revealed the resident was reported " " for 25 minutes. The record also revealed: "[ALF] caretaker states that she heard the , . (patient) after getting out of shower. Upon arrival , . was lying in hallway just outside of bathroom. was found lying on in full . . . . (. , . . .). . . and Advanced Life Support (. .) procedures were initiated and , . was transported to [hospital]". According to the National Center for . . , Information (NCBI), , is "referred to as flatline, represents the cessation of electrical and mechanical activity of the ". According to Zoll (a company which "develops and markets medical devices that help advance emergency care and save lives"), Advance Life Support (. . .) "is a set of life-saving protocol and skills that extend beyond Basic Life Support (BLS). It is used to provide urgent treatment to emergencies such as , ... , ... , and other conditions". During an interview on at 12:00 PM, Staff C (caregiver) stated, "I was not working. [Staff B] was working alone. [Resident # 1] had big . . . . . always and would . . . . . Supposedly he had 4 a while . When he would be . . . . . , we would give him aerosol".	A 030		

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A 030	Continued From page 72 During an interview on [redacted] at 12:35 PM, the Administrator stated, "[Resident #1] had [redacted], normally he would be [redacted]. It was a condition he already had. On the night of [redacted], he laid down at midnight and woke up to go to the bathroom. [Staff B] 'felt some type of movement' [sic] and went to see him. He stated that he wasn't feeling well, and [Staff B] called rescue. [Resident # 1] was alert, but with a lot of [redacted]. Rescue came and took vital signs and did the [redacted] and decided to take him to [hospital]. This was around 3:30 AM and 3:45 AM [sic]". The Administrator also stated, "to our knowledge, no one had COVID-19". A review of progress notes showed no documentation the facility staff had found out the resident's condition. On [redacted] at 1:05 PM, the Administrator stated regarding Resident # 1, "He has no family member or anyone that came to visit him. He doesn't have family. He has a friend. We called [Friend's Name] and he never picked up. We left him a message". On [redacted] at 1:10 PM, the Administrator then stated regarding Resident # 1, "The only one we had on file was [Friend's Name] until the day he [Resident # 1] [redacted] where we first spoke to his son, I don't know his name. Since I don't have any numbers of any family members, a week later, the [sister] called me. [Resident # 1's son] must have given his sister my number. The sister called me to find more information about him either on [redacted] or [redacted]. She [sister] stated that she tried to call him for 5 or 6 days at his cellphone and hasn't been able to talk to him". A review of Resident # 1's records showed a demographic sheet with three emergency contacts information such as their names, relationships to the resident, and telephone	A 030		

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A 030	Continued From page 73 numbers. In a continued interview on at approximately 1:10 PM, the Administrator also stated, "I called the social worker to let him know that he was hospitalized". On at 2:19 PM, Resident # 1's social worker stated, "Part of the long term care program he is in, we have to make monthly calls to check up on patients, and I called on the 18th and the 19th of . I called and the owner of the [ALF] told me that he was hospitalized. The next day I had called her because she told me that he went to [hospital] and I had called [hospital] and they told me that they had no patient by that name. That's when she [Administrator] told me that he ". On at 10:44 AM, Resident # 1's granddaughter stated the [Administrator] reached out to her dad around a week earlier and stated that Resident # 1's roommate also got sick and was hospitalized and . The granddaughter then stated the Administrator told her it was COVID-19". On at 11:44 AM, during an interview, another family member of Resident #1stated, "A week ago, she [Administrator] mentioned that [Resident # 1's roommate] also got sick and hospitalized and . She mentioned that it was COVID-19". On at 11:44 AM, during a continued interview, Resident # 1's family member stated, "She didn't even call me when he . My [family member] went to the facility in to visit [Resident # 1] and wanted to confirm that the new owners had the correct contact information. We found out he on . She [Administrator] said that she called [Friend's name], but [Friend's name] never received a call. [Friend's name] didn't even know until I told him. She lies to me about everything. When we	A 030		

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A 030	Continued From page 74 received all the documents, we found out the truth". During a phone interview on at 3:47 PM, Staff B stated, " When a resident isn't well, I call 911 and do what they say." A review of Staff B's (caregiver) personnel record showed she was hired on and a , Automated External Defibrillator ( ), and Basic First Aid certification was issued on . Further review of the ambulance run record for Resident # 1 showed: " : Yes, Prior to Arrival". The run record also showed: " Prior to ? No". Further review of Resident # 1's records showed no documentation of a , , , or Resident # 1's 2) A review of the admission and discharge log showed Resident # 2 , on due to natural causes. A review of Resident # 2's health assessment dated showed Resident # 2 was diagnosed: , , , , , Major , , , , , Small , Diverticulosis, of . She also required supervision with eating and self-care (grooming) and needed assistance with ambulation, bathing, , toileting, transferring, and self - administration of medication.	A 030		

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A 030	Continued From page 75 A review of Resident # 2's records showed a goldenrod-colored Florida ... (... Form # 1896) signed by her Power of Attorney (POA) dated . A review of fire rescue's ambulance run record showed ... arrived at the facility on ... at 4:03 am. The record showed the chief complaint was that Resident # 2 had been "unresponsive" for a duration of one hour and gave a primary impression of ... upon arrival". Further review of the run record showed: "Staff at [ALF] states, "they checked on her an hour ago and found her ... and pale but went about their routine. Went ... to check on ... (patient) and then called 911 when they could not wake her." Hx (History) of ... and ... found on floor with [police department] performing ... . HEENT (...) ... and ...) normal. ... fixed and dilated. No ... (...) ... x 3 leads. Skin ..., rigor to jaw and lividity to ... of ... . Bed soiled with fecal matter. ... to ... unremarkable. ... on arrival. ... assessed and termed ... [Police Officer] on scene. ... on scene". A review of Resident # 2's records showed no documentation Resident # 2 was found ' ... and pale' for an hour before having to call ... . There was also no documentation a medical provider or family was contacted when Resident # 2 was found ' ... and pale'. Further review of Resident # 2's records showed the last documented progress note was dated ... . There was no documentation of Resident # 2 being found unresponsive and declared ... by ... upon arrival.	A 030		

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A 030	Continued From page 76 On at 9:41 AM, when asked if Staff C knew what a meant, Staff C stated, "No, I don't know what it means. I don't think anyone here has one". Interviewed on at 12 PM, Staff C stated regarding Resident # 2's , "During the morning, I went to go see her because it was time for breakfast, she wasn't breathing. She wouldn't respond. [Staff B] was the one that saw her first. She called 911. I waited while she called 911". However, a minute later, Staff C then stated, "911 told me to do , and I would do the , . They would count for me. 911 came right away and then the administrator took over. She didn't have a , ". Staff C then stated, "I called 911. [Staff B] called me and I checked for , ". Staff C then demonstrated where she checked for Resident # 2's , pointing to her . Staff C also stated regarding the , "She didn't have one, so we called 911 and they instructed us". A review of Staff C's personnel records revealed a certificate of in-service training dated that showed Staff C was trained on the facility's Policies and Procedures. The certificate also showed that the Administrator conducted the training. Further review of Staff C's personnel records revealed an In-Service Training regarding 'Resident Rights in an ALF & Recognizing & Reporting , Neglect, & , ' and 'Resident Behavior and Needs, & Providing Assistance with ADLs'. Interviewed on at 12:35 PM, the	A 030		

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A 030	Continued From page 77 Administrator stated, "In the morning, one of the caretakers, [Staff B], who no longer works here, woke up to eat breakfast. She [Resident # 2] wasn't responding, rescue was called, and rescue declared she was . [Staff B] tried to . She was following instructions rescue gave her. I wasn't here. Her son was called. Her son called the funeral home and arranged the pick-up". During an interview on at 3:47 PM, Staff B stated through a phone interview, "I've been trained the same way they train everyone for . 911 gives me instructions on how to do . When a resident isn't well, I call 911 and do what they say. I remember doing on [Resident # 2], I don't remember the other names". A review of the facility's policies and procedures showed a description which stated, "A directs staff not to apply lifesaving skills (ex:)". Interviewed on at 9:33 AM, when asked how to perform , Staff C demonstrated how she would give , . Staff C then stated, "I call 911 and they count for me. They count a lot. I've done it before to [Resident # 5] and to [Resident # 2]. 3) A review of facility records showed no documentation for Resident #5. The resident was not listed on the facility's admission/discharge log. There was no documentation of a Medication Observation Record for the resident.	A 030		

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A 030	Continued From page 78 A review of fire rescue's ambulance run records showed arrived at the facility on at 03:27 am. The record showed that the primary impression of Resident # 5 was documented as " Upon Arrival". The record also revealed: "Upon arrival, R-41 (Rescue 41) found a non-viable patient in an [ALF] laying alongside her bed unresponsive with a GCS (Glasgow Scale) of 3. Absent ". On at 9:33 AM, when asked how to perform , Staff C stated, "I call 911 and they count for me. They count a lot. I've done it before to [Resident # 5] and to [Resident # 2]. On at 9:36 AM, Staff C stated regarding Resident # 5, "[Resident # 5] was only here for a few days. She had ; she had a ". On at 12 PM, Staff C then stated, "I put her to bed at approximately 1 AM and saw her breathing very bad. I called 911. 911 told me to do . She was still breathing, and she had a very slow , ". There was no documentation of what happened between 1AM, when Staff C found the resident 'breathing very bad' and 3:27 AM, when rescue arrived. During an interview on at 4:05 PM, the Administrator stated, "She was admitted on . She was here for a few days because her family wanted to see if she would get accustomed to the ALF. [Staff C] was working. [Staff C] called me and told me that she had woken up and [Resident # 5] would usually scream at night and [Staff C] went to check on her because she wasn't screaming that night. She called me and told me that she didn't see [Resident # 5] well and I told her to call rescue. Rescue came and declared her ".	A 030		

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	AL11969050	A. BUILDING: _____ B. WING _____	09/23/2020

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A 030	Continued From page 79 A review of Resident # 5's records showed no documentation Resident # 5 was screaming at night, coughing, or receiving any kind of medical care prior to passing away. 4) On at 10:10 AM, a family member of Resident #9 was observed entering the facility without being screened or signing the visitor log. Facility staff did not check his temperature, nor did he complete the COVID-19 questionnaire. The family member was wearing a facemask and proceeded to the dining table to talk to Resident #9. There was no social distance maintained between the two. A review of the facility screening record on at approximately 10:15 AM showed no documentation that the visitor was screened by the facility staff. 5) A review of the Department of Health records showed the Administrator tested positive for COVID-19 on , , and . The Administrator tested negative for COVID-19 on . On at 9:54 AM, observed the Administrator enter the assisted living facility. Personnel record review revealed no documentation of a medical clearance for Staff A. A review of the Department of Health records showed that Staff D (Co-owner) tested positive for COVID-19 on , and . On at 12:00 PM, observed Staff D	A 030		

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A 030	Continued From page 80 enter the assisted living facility. Personnel record review revealed no documentation of a medical clearance for Staff D. Class I	A 030		
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 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	A 053		

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A 053	Continued From page 81 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 observation and record review, an unlicensed staff administered medications to one out of 11 sample residents (Resident#9). Finding include: A review of the health assessment Resident#9 required assistance with self-administration of medication. Observation at approximately 9:40 AM on revealed Staff C, a caregiver, gathered all of Resident #9's morning medications. Staff C went to Resident #9 and placed all of the medications into the resident's instead of assisting with self-administration of medication. A review of Staff C's personnel record on showed no documentation of a nursing license. 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	A 054		

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A 054	Continued From page 82 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 [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone 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 [illegible], 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 interview and record review, the facility failed to maintain a daily Medication Observation Record (MOR) for two out of 11 sampled residents who required assistance with self - administration of medication (Resident # 2 and # 9) . Findings Include:	A 054		

Agency for Health Care Administration

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A 054	Continued From page 83 On at approximately 8:30 AM, Staff C stated that the facility's census were 3 residents. A review of the facility's Medication Observation Record binder showed a MOR for only Resident # 7 and # 10. There was no documentation of a MOR from a pharmacy or a handwritten MOR from the facility for Resident # 9. A review of Resident # 9's health assessment dated showed she required assistance with Self - Administration of medications. On ... . at 8:57 AM, Staff C stated, "There's no paper for [Resident # 9]. She just arrived 4 days ago. I don't sign anything for her". Class III	A 054		