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
	AL11910977	A. BUILDING: _____ B. WING _____	R 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit COVID-19 control and Generator Monitoring was conducted at Las Mercedes Boarding Home on through . . . . Deficiencies were identified at the time of survey.	{A 000}		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be	A 077		

AHCA Form 3020-0001

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

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A 077	Continued From page 1 under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:	A 077		

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A 077	Continued From page 2 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile [illegible] of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not [illegible], serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, [illegible], which is incorporated by reference and available online at:	A 077		

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A 077	Continued From page 3 http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an administrator capable of handling the operation of the facility, including the management of all staff and the residents. The Administrator failed to complete the required training and education, including the core competency training and certification examination , within 90 days after the date of employment as an administrator. The administrator failed to ensure that the facility followed control policies and procedures. Thirteen residents tested positive for COVID-19, and the Administrator was not aware of the (Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 14, 16, 17, and19). Four of the residents due to complications from COVID-19 (Residents # 6, 7, 10 and 17). The administrator removed positive COVID-19 resident test results from facility records during an inspection, presenting only negative test results. The administrator failed to ensure that trained staff fulfilled their duties by providing to two residents who onsite and did not have a (Resident #1 and #4). Findings included: 1) A review of the facility's Administrator/Manager job description showed that "Administrator/Manager is in charge of the entire operation of the ALF and is responsible for all personnel supervision to assure that all the residents' needs are met. This includes the	A 077		

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A 077	Continued From page 4 conduct of the employees and assurance of the wellbeing of other residents in the ALF with whom he/she has to be tolerant and respectful at all times." It also said "Administrator/Manager shall employ staff in accordance with Rule 58A-5.019(6) . Assure that the employee is mentally and physically capable of performing their assigned duties," and " ...is responsible for the development and implementation of the arrangements for health care." During an interview on [redacted] at 11:30 am, the Assistant Administrator (Staff A) stated "I bought the facility in [redacted], of this year. Your agency has all the documentation about the change of ownership. You do not need to talk with [Owner of Record] because he is not the facility's owner. He is an old man and is [redacted]." A review of a Change of Administrator documents received by the Agency for Health Care Administration showed that the Assistant Administrator (Staff C) was listed as the Administrator as of [redacted]. A review of a second Change of administrator document showed that the Administrator (Staff B) was listed as administrator effective [redacted]. Staff A was not listed on any document. A review of the Assisted Living facility Core Competency Test Successful Examinees Database showed no documentation that Staff A, B or C had completed the Core Competency Test. As of [redacted], the facility had been without a qualified administrator for more than five months (150 days.) 2) Review of facility records, laboratory test results,	A 077		

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A 077	Continued From page 5 hospital records and state health agency records showed that Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, 14, 16, 17 and 19 tested positive for COVID-19 between , and of 2020. Residents #6, 7, 10 and 17 of complications of COVID-19. Residents COVID-19 positive test results were: Resident # 2, Medical Labs, positive on , . Resident #3, Medical Labs, positive on . Resident #4, Medical Labs, positive on . Resident #5, Medical Labs, positive on , . Resident #6, Hospital Record, positive on . Resident #7, Hospital Record, positive on , Medical Labs, . Resident #8, Hospital Record, positive on . Resident #9, Hospital Record, positive on . Resident #10, Hospital Record, positive on . Resident #14, Another State agency, positive on . Resident #16, Hospital Record, positive on . Resident #17, Hospital Record positive on . Resident #19, Medical Labs positive on . Photographic evidence and or observation of test results for Residents #2, 3,4,5,6 and 19 was obtained from the facility's 'COVID-19 documents' binder on . Facility record review on at 10:00 AM showed the positive resident COVID-19 test results were removed from the binder. Facility record review showed three staff tested	A 077		

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A 077	Continued From page 6 positive for COVID-19 (Staff D/Assistant Administrator 2- positive on , Staff E- positive on , Staff H- positive on and). There was no documentation that steps were taken to prevent the spread of the to other residents and that Staff D, E or H obtained medical clearance to return to work. Further Resident record review showed: Resident #3 was tested on and a day later ( ) he was hospitalized due to and . Hospital records showed she arrived at the hospital " , poorly responsive, and a low ". Resident # 3 was positive for COVID-19. Resident #4 tested positive for COVID-19 on and she was hospitalized on because she had . The Administrator stated that Resident # 4 of a on . There was no documentation that the resident received medical care after testing positive. Resident # 6 was hospitalized on because he had (,). Hospital records showed the resident was hospitalized with , , and , . The resident was also positive for COVID-19 on admission and was discharged on to a rehabilitation center where he on . Resident #7 tested positive for COVID-19 on and on . The resident was sent to the hospital on . Hospital records revealed the resident arrived at the hospital with and , . Resident # 7's certificate showed the cause of was	A 077		

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A 077	Continued From page 7 COVID-19- . . . . . There was no documentation that the residents received medical care after the positive diagnoses. Resident #10 was hospitalized on . . . . . because he had a . . According to another State agency, Resident # 10 tested positive for COVID-19 on admission at the hospital on , ... , ... and then . . . on . . . . . . Resident # 17 was discharged from the facility on . . According to another State agency, Resident #17 tested positive for COVID-19 on admission to the hospital on and on . . . . . at the hospital. The facility did not have any documentation Resident # 17 tested positive for COVID-19. Record review showed Resident #18 was under hospice care and tested positive for COVID-19 on . . . . . and . . . on . . . . . under continuous care. A review of the ESS (Emergency Status System) showed 4 reports from the facility that residents had tested positive for COVID-19 in , or , of 2020. There were no records of the 13 positive COVID-19 cases beginning in having been reported in the ESS. A review of records from another State Agency showed that the facility reported two cases of COVID-19, on . . . . . and . . . . . The department recorded three total deaths at the facility as of . . . . . , ... Another State agency documented no contacts from the facility requesting testing for residents. On at 9:29 AM, Staff C stated that he spoke with the facility daily, and there were no positive cases. He stated that he reported daily	A 077		

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A 077	Continued From page 8 to the ESS system. He stated that he did not recall the State agency coming to the facility, but that all residents were tested. Observation on [redacted] between 9:00 and 11:00 AM revealed that the census of 10 residents were not wearing facemasks. On [redacted] at 11:00 AM, the Owner stated the residents were not using masks because he tried to get them to wear masks, but they always took them off because they didn't like it. He said he was out of the country and Staff C (Administrator) was in charge of the facility until . On at 11:15 AM, the Administrator (Staff B) stated, "We did not have any deaths related to COVID-19. The residents that were sent to the hospital had unrelated symptoms of COVID-19. The residents were positive at the hospital a few days later. The residents were of COVID-19 in the hospital." He stated they did not know if the current residents were COVID-19 positive because they have not been tested. He said he did not contact Resident's #4 healthcare provider either or wrote any documentation in her record because he reported he "did not have time". 3) a) A review of Resident #1's health assessment dated showed diagnoses of 's [redacted] decline, ( ), ( ) [redacted] He needed supervision in bathing and [redacted] and assistance with self -administration	A 077		

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A 077	Continued From page 9 of medications. Further review of Resident # 1's record showed no documentation of a {}. There was no documentation that Resident #1 was under the care of a health care provider. A review of the admission/discharge log showed that Resident #1 onsite on . Review of Resident #1 record showed he was admitted on . The health assessment done on the physician indicated the resident was diagnosed with 's , decline, . The resident needed supervision with bathing and and assistance with the rest of the activities of daily living. There was no documentation of a , COVID-19 test results and that he was under the care of a health care provider. On at 8:35 AM, Staff E confirmed that she went to Resident's #1 room, saw him and observed Staff J check the resident's . On at 9:45 AM, Staff J stated he did not perform , , ( ) on Resident #1. He said that because he was a nurse in Cuba, he knew that the resident was , and was not necessary. He stated the resident was seen having dinner at around 5 pm on , then 20 or 30 minutes later, he saw unresponsive and pale. He stated he checked the resident's , and his by using a PulseOx machine, and he determined the resident was already . According to WebMD, " oximetry, or , ox, is a quick and needle-free test that measures the amount of in your . It shows	A 077		

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A 077	Continued From page 10 whether your [illegible] and [illegible] supply enough to meet your body's needs." b) Review of Resident #4's health assessment dated [illegible] showed the resident was diagnosed with [illegible] / uncomplicated, [illegible], primary generalized [illegible], sleep [illegible], unspecified major [illegible], mild, [illegible] state. The resident needed assistance in all activities of daily living (eating, ambulation, bathing, [illegible], self-care, toileting and transferring). There was no documentation of a [illegible]. A review of the ambulance run record showed that Resident #4 was found on her bed at the facility. She had no [illegible] and was not breathing. Rescue staff-initiated [illegible] and continued it while transferring the resident to the hospital. A review of the hospital record revealed that the rescue efforts continued for about 45 minutes before they were discontinued, and Resident #4 was declared [illegible]. On [illegible] at 10:00 AM, Staff K stated she found Resident #4 panting, 'agitated' and unable to speak on [illegible] at 4:30 AM. She stated she took Resident #4's temperature and [illegible], and found those to be 'normal' ([illegible] and the temperature was 97.5). She said she touched the resident's [illegible] and called her by name, and the resident did not respond, then she called Staff I. She said they took resident's #4 [illegible] again and found it low ( ), so went to the other building where the charts were kept, to get the demographic sheet, and called 911. She stated	A 077		

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A 077	Continued From page 11 she returned to the room and 'pressed on [the resident's] ' a few times but the resident did not respond. She said resident's , . . . was not taken again and she was unable to express clearly whether or not the resident was breathing. She stated Resident #4 was alive when rescue removed her from the facility. She stated that she and Staff I performed by touching the resident's . . . . and pressing on it a few times. She states the resident was alive because her body was moving during the . . Staff record review showed Staff J received . training on and training on . . . . . ; Staff received . trained in . . . . . and trained on ; Staff K received . trained on . . . . . and . training on ; and Staff I received training on . . . . . and . training on . . . . . . Facility's . . . . . & Advanced Directives policies review showed "The facility will carry out the legal and medical wishes of a . . . . . that has been completely filled out by resident/legal representative/guardian and a physician." The facility did not provide a policy regarding . . . . . (.). Observation on . . . . . at 9:30 AM showed there were 10 residents living in the facility who were in danger of not receiving . if they become unresponsive. Class I	A 077		
{A 078} SS=J	59A-36.010(2) FAC Staffing Standards - Staff	{A 078}		

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{A 078}	Continued From page 12 (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	{A 078}		

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{A 078}	Continued From page 13 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 record review and interview, the facility failed to ensure that staff performed their assigned duties and responsibilities consistent with their qualifications, trainings, preparation and experience. Staff did not perform ( ) for two of 21 sampled residents who did not have a . . . . (. .) in place and became unresponsive, with no , . . . and no breathing (Resident #1 and #4). The facility also failed to have evidence of a negative . . . . . examination documented on an annual basis for one of eleven staff (Staff C) sampled staff.	{A 078}		

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{A 078}	Continued From page 14 Findings included: 1} A review of Resident #1's health assessment dated . . . . . showed diagnoses of . . . 's . . . decline, (. . .), ... (. . . . .) . . . . He needed supervision in bathing and . . . . and assistance with self -administration of medications. Further review of Resident # 1's record showed no documentation of a . . . . (. . .). There was no documentation that Resident #1 was under the care of a health care provider. A review of the staffing schedule showed that Staff J, Staff E and Staff I (caregivers) were on duty on . . . when Resident #1 . . A review of personnel records showed that Staff I was . . trained on . . . . . , . . . trained on . . . and Staff J was . . . trained in . . . and trained regarding . . . . on . . . . . . A review of the resident record showed one observation note dated . . . stating, "[Resident #1] , ... , on . . . . At 5:30 PM employee [Staff J] found resident . . . in his room. At 4:30 took dinner and went to his room. At 5:30 staff called the Administrator and informed he was found . . . . in his room. Son was called and came to facility observing father . . . . in bed (sic). Police was called Case number [ ]." Interviewed on . . . . . at 9:45 AM, Staff J (caregiver) stated that on . . . at around 5:00 PM he saw Resident #1 having dinner then, 20 or 30 minutes later, he found the resident	{A 078}		

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{A 078}	Continued From page 15 . . . . . Staff J stated that he did not perform , , ( ) on Resident #1. Staff J stated that because he was a nurse for 35 years in another country, he knew that the resident was . . . . , and . was not necessary. On at 8:35 AM, Staff E (caregiver) confirmed that she went to the Resident #1's room, saw him and observed Staff J check his , ... A review of the ambulance run record regarding Resident #1's showed that when emergency services personnel arrived at the facility on they placed the resident on the floor and started . . On . . . . . at 8:00 AM Staff E stated she believed Staff J did not give to Resident #1 'because resident was already . . . . .'. She stated Staff I was trained and had experience to perform . . On . . . . . at 8:35 AM Staff D stated she believed Staff I did not perform on Resident #1 'because he got nervous when saw the resident .' 2) Review of Resident #4's record showed she was admitted to facility on . . . . . Her health assessment dated showed diagnoses and medical history of . . . . . , uncomplicated, , , unspecific , , ... , primary generalized osteo- , , , , . . . , sleep	{A 078}		

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{A 078}	Continued From page 17 She stated the resident did not respond. Staff K said that she observed the fire rescue personnel performing . once they arrived (at 5:09 AM). Staff K stated that she saw Resident #4 alive when fire rescue personnel removed her from the facility. She stated the resident was alive because her body was moving during the . . She stated that resident # 4 did not have a . Further interview with Staff K on at 2:40 PM, revealed that she or Staff I did not place the resident on the floor to begin . The interview revealed that Staff K or I did not provide the recommended cycles of two breaths and 30 , until rescue arrived, as described by the American Association regarding the actions health care professionals should take for people found with no , who are not breathing, and who do not have a . . A review of the ambulance run record and the hospital record showed that Resident #4 was found on her bed at the facility. She had no , and was not breathing. Rescue staff placed the resident on the floor, initiated and continued it while transferring the resident to the hospital. A review of the hospital record revealed that the rescue effort continued for about 45 minutes before being discontinued, and Resident #4 was declared . A review of Resident # 4's record found no documentation of a . . Further review showed no documentation about the resident's . There was no documentation that the facility informed the resident's family and primary healthcare physician of her . A review of facility records showed no policy regarding , however a review of the facility's	{A 078}		

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{A 078}	Continued From page 18 . & Advanced Directives policies showed: "The facility will carry out the legal and medical wishes of a . . . . . that has been completely filled out by resident/legal representative/guardian and a physician." 3) Staff record review showed the facility did not have documentation that Staff C (previous administrator) was free from communicable . . . . . . On . . . . . at 11:00 AM the Administrator (Staff B) stated he believed the statement for Staff C should be Staff C's records, but the Administrator was unable to provide it. Uncorrected Class 1	{A 078}		
{A 161} SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 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	{A 161}		

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{A 078}	Continued From page 16 , unspecific major , single episode, mild, , state, inspect; other of , -protein metabolism, OA/ (/ ,), NEC ( ), on right heel, . She needed assistance in all activities of daily living (eating, ambulation, bathing, , self-care, toileting and transferring). She needed assistance with self-administration of medication. Facility record review showed Resident # 4 became unresponsive (no , , no breathing) on . A review of the staffing schedule showed that Staff K and Staff I (caregivers) were on duty on when Resident #4 . A review of personnel records showed that Staff I was trained on , trained on and Staff K was trained on , and trained regarding on . On at 2:30 PM, Staff K (caregiver) stated that on at around 4:30 AM, she found Resident #4 panting, 'agitated' and unable to speak. Staff K further stated that the resident did not respond in any way even when staff called her by name or touched her . Staff K said she took Resident #4's temperature and , and found those to be 'normal' (, and the temperature was 97.5) then called Staff I. Staff K stated she and Staff I (caregiver) took the resident's again and found it low ( ). Staff K stated she then went to the other building (where the charts were kept) to get the demographic sheet and called 911. She said she returned to the room and 'pressed on the resident's a few times.'	{A 078}		

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{A 161}	Continued From page 19 (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. (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.	{A 161}		

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{A 161}	Continued From page 20 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have a completed job application with references for one out of eleven sampled staff (Staff H). Findings included: Personnel record review revealed Staff H was hired on [redacted] and had no references listed on their job application. On a 12:41 PM the owner acknowledged there were no references listed on the job application. Uncorrected Class III	{A 161}		
A 168 SS=D	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident	A 168		

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A 168	Continued From page 21 or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of . . . . or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or . . . . of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. 429.27, FS Property and personal affairs of residents. - (7) In the event of the of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the	A 168		

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A 168	Continued From page 22 time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's , the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide the prorated refund based on the daily rate for any unused portion of payment for one out of 21 (Resident #21) sampled resident. Findings included: A review of the facility's refund policy revealed that refunds are given 45 days following the date of termination of residency. Review of Resident #21 record showed Resident #21 was admitted on and expired on . Resident's contract dated showed the resident paid a deposit of $3000.00 and had a monthly rent of $3000.00. Further review revealed that Resident's #21 representative is entitled to receive $5612.00,	A 168		

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A 168	Continued From page 23 which includes the deposit payment of $3000.00 and a prorated refund in the amount of $2612.00. Interviewed on at 1:20 PM, Owner acknowledged that Resident #21's representative is entitled to a prorated refund in the amount of $5612.00. He stated that he would send the amount to Resident's #21 representative. Class III	A 168		
{A 200} SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident	{A 200}		

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{A 200}	Continued From page 24	{A 200}		

must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an

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LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

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{A 200}	Continued From page 25 alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite.	{A 200}		

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LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

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{A 200}	Continued From page 26 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that	{A 200}		

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	AL11910977	A. BUILDING: _____ B. WING _____	R 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

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{A 200}	Continued From page 27 undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule.	{A 200}		

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{A 200}	Continued From page 28 (b) The Agency shall allow an extension up to , , to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or	{A 200}		

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{A 200}	Continued From page 29 b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to	{A 200}		

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{A 200}	Continued From page 30	{A 200}		

produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration;
3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and
4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy.
(b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request.
(c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law.
(6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines.
(7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.
(a) Assisted living facilities whose comprehensive emergency management plan is to evacuate

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{A 200}	Continued From page 31 must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have the emergency power plan (EPP) approval letter available for review. Findings included: Review of the facility's Emergency Environmental Control Plan Policies and Procedures showed no documentation of emergency power plan (EPP)	{A 200}		

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{A 200}	Continued From page 32 approval letter. On [redacted] at 12:55 PM, Staff A stated, "no we do not have it (referring to the EPP letter)." Uncorrected Class III	{A 200}		