

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 _____ 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 _____ 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; _____; 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 observation, record review and interview, the facility failed to maintain the current employment status of all employees within the clearinghouse by reporting initial employment status within 10 business days. One of seven sampled staff was not listed. (Staff G). Findings included:	CZ814		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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	Continued From page 1 On _____ at 9:45 AM, observed Staff G working at the facility. Review of the facility's roster showed that Staff G was not listed. Interviewed at approximately 9:50 am, Staff G stated that she worked in other facilities, and had been working at this one for about a month. Review of the background clearinghouse showed Staff G had an eligible date of _____. On _____ at 11:50 AM, In reference to the new staff, the administrator stated she would contact the consultant and the new staff would be added on the same day. Unclassified	CZ814			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144			
(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 Re-licensure Revisit was conducted at Amistad 308, LLC on 11, 2020. Deficiencies were identified at the time of the survey.	{A 000}			
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	A 055			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 055	Continued From page 1 been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued 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	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 055	Continued From page 2 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 resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all medications were centrally stored and kept in a locked cabinet, locked cart, or other locked storage receptacle, room or area at all times. Findings included: On at 10:10 AM, In the kitchen, inside one of the unlocked cabinets, the facility had medication for Resident 6 (..... 10 mg). and on the top shelf, medications for Resident 7. On at 10:10 am, Staff B stated that the medications needed to be returned, since they belonged to a resident who had just , , and the other medication was for a resident in daycare, Resident 6. Class III	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 162} {A 162} SS=D	Continued From page 3 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 paragraph. A documented request for such missing documentation made by the facility administrator within the previous 30 days will be	{A 162} {A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 162}	Continued From page 4 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 record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if 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 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.	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 162}	Continued From page 5 (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 of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 162}	Continued From page 6 (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have a prescription for the use of half or full bed rails for Residents 1, 2 and 5. In addition, the facility failed to have an accurate health assessment for Resident 2. Findings included: On at 9:55 AM, during the tour of the facility, observed in: - Resident 1 (Hospice, full bed rail), - Resident 2 (full bed rail on one side, ½ bed rail on the other) - Resident 5 (bed rail) Review of Resident 1's record showed the resident was receiving hospice care, and there was an expired prescription for a full bed rail dated Review of Resident 2's record showed a prescription for half bed rails dated According to the administrator and Staff B, the resident was under hospice care in The administrator stated that the doctor removed the resident from hospice care, and he was re-admitted in after being hospitalized. There was a prescription for hospice evaluation dated A review of the resident record showed a health assessment dated The resident had a diagnoses	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 162}	Continued From page 7 of _____, gait difficulty, and memory loss with _____ precautions. The resident needed supervision with eating, assistance with ambulation, toileting and transferring; he needed total assistance with bathing, _____ and grooming. Review of Resident 5's record showed a prescription for hospital bed with bed rails, dated _____. The prescription did not specify the size of the bed rail. On _____ at 11:50 AM, the Administrator stated in reference to the health assessment for Resident 2, she would speak to the doctor right away. Uncorrected Class III	{A 162}			
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. 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	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 8 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; I. 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	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 9 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. 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.	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144			
(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 10 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 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	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 11 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 disinfection supplies; and 6. Adequate capacity at referral hospitals for the facility. ii. General visitors must: 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	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 12 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 feet 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 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	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 13 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: 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.	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 14 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; iv. 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 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	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144		
(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 15 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 documentation must include the screening employee's printed name and signature. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of its policy and procedures for family members and friend regarding visitation during the COVID-19 public health emergency.	A1300			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/11/2020
NAME OF PROVIDER OR SUPPLIER AMISTAD 308 LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8420 SW 2ND STREET MIAMI, FL 33144			
(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 16 Findings included: Review of the facility's records showed the facility did not have a policy and procedures for visitations other than essential workers. Observation on 12: ... at approximately 9:55 am showed that Staff B called the consultant, and further observation showed that the paperwork was sent by email. On ... at approximately 10:00 am, Staff B stated that the facility was going to give the documents to the family members for review and signatures. Class III	A1300			