

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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
CZ813	59A-35.090(3)(c), FAC Results of Screening & Notification in File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a signed Background Screening - Compliance Attestation form for one out of two sampled staff (Staff B). Findings Include: A review of Staff B's personnel records showed she was hired on _____ and a level II background screening completed on _____. Further review of Staff B's personnel records showed no documentation of a signed Background Screening - Compliance Attestation form. On _____ at 9:38 AM, the Administrator stated, "No I don't have it. It's not here". Class III	CZ813		
CZ814	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	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: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 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 record review and interview, the facility failed to maintain an updated employee roster within the background screening clearinghouse database for two out of two sampled staff (Administrator and Staff B). Findings Include: A review of the facility's background screening database roster showed neither the Administrator or Staff B were registered as an employee. A review of the Administrator's personnel records showed a hire date of _____ and an eligible _____	CZ814			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 2 level II background screening dated A review of Staff B's personnel records showed a hire date of and an eligible level II background screening dated On at 9 AM, the Administrator stated, regarding updating the background screening database roster, "I didn't know. Let me see if I can do it now". Unclassified	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 resident wellness monitoring survey was conducted at Karelis Home Care, LLC on . Deficiencies were identified at the time of the survey.	A 000		
A 007 SS=D	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ... () ... may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires	A 007		

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: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 007	Continued From page 1 the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any _____ or 4, _____. A resident requiring care of a _____ may be admitted provided that: a. The resident either: (i) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (ii) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and, c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. _____ airway management of any kind, except that of continuous positive airway	A 007		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 007	Continued From page 2 pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with _____ c. Monitoring of _____ gases, d. Management of post-surgical drainage tubes and _____ vacuum devices; e. The administration of _____ products in the facility; or f. Treatment of surgical _____ or _____ unless the surgical _____ or _____ and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. _____ and _____ performed in the facility; b. _____ performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities	A 007		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 007	Continued From page 3 established in rule chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable _____ or assistance with routine _____ care of _____ site _____ placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from _____ with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria. (e) Resident admission criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that one out of two sampled residents met the minimum admission criteria (Resident #1). Findings as follow:	A 007		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 007	Continued From page 4 On _____ at 7.35 AM Resident #1 was observed lying in bed with full bed rails in upright position. Record review showed resident was admitted to facility on _____. The resident's health assessment dated _____ showed a diagnosis of "Bed confinement status" and documented the resident needed total assistance with all activities of daily living. On _____ at 7.45 AM Resident #1 stated he was unable to walk. On _____ at 8.30 AM the Administrator stated Resident #1 was admitted to facility under Hospice care and bedridden. Class III	A 007		
A 030 SS=D	59A-36.007(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 5 policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe,	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 7 impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making for health care services, the provision of or arrangement of transportation to health care	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 ... and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ill, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, and	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 9 prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated _____ or _____ under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to respect one out of two residents' rights (Resident #1) to be free of _____. The resident was prevented from getting out of bed without staff assistance by full bed rails not prescribed for the resident's use, and which the resident was unable to remove without assistance. Findings as follow: On _____ at 7.30 AM Resident #1 was observed lying in bed with full bed rails in the upright position. Further observation showed that the resident was unable to remove the bed rails. Review of Resident #1's record showed no prescription for the use of bed rails. Review of Resident #1's health assessment date showed resident needed total assistance with all the activities of daily living. Further record review showed resident was under Hospice care. On _____ at 8.30 AM the Administrator stated Resident #1 was bedridden and he was unable to do any activity or to remove the bed rail without assistance. She said would request the bed rail prescription for Resident #1 from the Doctor.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 11 Class III	A 030			
A 052 SS=D	429.256() ; 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an _____ syringe that is prefilled with the proper dosage by a pharmacist and an _____ that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident 's medications or dosages change. (c) Placing an oral dosage in the resident 's _____ or placing the dosage in another container and helping the resident by lifting the container to his or her _____. (d) Applying _____ medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 052	Continued From page 12 removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (h) Using a _____ to perform _____ level checks. (i) Assisting with putting on and taking off _____ stockings. (j) Assisting with applying and removing an _____ but not with titrating the prescribed _____ settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with _____ bags. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 052	Continued From page 13 resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 052	Continued From page 14 resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 052	Continued From page 15 assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to follow the correct procedures outlined by the state when assisting one out of two sampled residents (Resident # 2). Findings Include: On at approximately 9:30 AM, observed Staff B unlock the medication cabinet and grabbed a medication pack. Staff B then popped the medication from the pack into a small white cup and passed the cup to the resident. Staff B then turned around and initialed the Medication Observation Record (MOR). Staff B did not advise Resident # 2 of the name and dosage of the medication nor removed the prescribed amount of medication in the presence of the resident. Staff B also did not observe Resident # 2 take the medication. A review of Resident # 2's MOR showed the name of medication given to Resident # 2 was 500 mg Tablet. A review of Staff B's personnel records showed a training certificate of 6 hours on Assistance with Self - Administration of Medication dated Class III	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 077 A 077 SS=D	Continued From page 16 429.176 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 meets educational requirements and 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 facility administrator must complete the required core training, including the competency test, within 90 days after the 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 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.,	A 077 A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 077	Continued From page 17 and this rule chapter. (a) An administrator must: 1. Be at least _____; 2. If employed on or after _____, 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 _____, 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 _____ 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: 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.	A 077			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 077	Continued From page 18 (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 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 , 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 , 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, , which is incorporated by reference and available online at: 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 ensure the Administrator completed the	A 077			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 077	Continued From page 19 required CORE competency test requirements within 90 days after the date of employment as an Administrator. The facility also did not have a CORE trained Administrator for more than 120 consecutive days. Findings Include: A review of the Administrator's records revealed a hire date of _____ and a CORE training certificate dated _____ through _____. Further review showed no documentation that the Administrator had passed the CORE competency test, such as a CORE identification card. A review of the online database for a 'List of Successful Examinees' showed no evidence the Administrator successfully passed the CORE competency test. On _____ at 8:19 AM, the Administrator stated, "I've taken it twice. The second time I took the exam was on _____ and waiting for the results". Class III	A 077			
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to	A 085			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 085	Continued From page 20 administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the staff responsible for the facility's meals completed 2 hours of continuing education regarding nutrition and food service for one out of two sampled staff (Staff B). Findings Include: On _____ at approximately 8:30 AM, observed Staff B in the kitchen preparing breakfast for Resident # 2. A review of Staff B's personnel records showed a hire date of _____ and showed no documentation of a completed training regarding nutrition and food service. On _____ at 8:47 AM, the Administrator stated, "If it's not here, I'll have her do it". Class III	A 085			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name,	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 21 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 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. (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)(e), 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.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 22 (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. (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.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 23 (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 the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (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. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that two of two sampled resident	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 24 records contained the required documents (Residents #1 and #2). Have a copy of a health Assessment form, AHCA Form 1823 as described in rule 59A-36.006, F.A.C. for two out of two residents Have a contract executed between two out of two residents and the facility (Residents #1 and #2). Have the interdisciplinary care plan and documentation for one out of two residents who is under Hospice care (Resident #1) Findings as follow: Record review showed the Health Assessments of Resident #1 (dated) and Resident #2 (dated) were completed on an outdated form version (dated). The form was missing crucial information about resident care as whether the residents were at risk of elopement. Further review showed no documentation of a contract between the facility and Resident #1 or #2. Review of Resident #1's Hospice record showed it did not include the interdisciplinary care plan. On at 8.30 AM the Administrator stated she did not know there was an updated health assessment form. She added would ask the primary physician to complete updated health assessments for Residents #1 and #2 and the Hospice staff to place Resident #1's Care Plan in the Hospice record kept in facility. She further stated she believed Resident #1 and #2's contracts were in their records. Class III	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1300	Continued From page 25	A1300		
A1300 SS=D	Dem Emerg Order 20-011 Visitation 1. Every facility must continue to prohibit the entry of any individual to the facility, except in the following circumstances: A. Family members, friends, and individuals visiting residents in end-of-life situations including any resident enrolled in hospice; B. Hospice or _____ care workers caring for residents in end-of-life situations including any resident enrolled in hospice; C. Any individuals or providers giving necessary health care to a resident, provided that such individuals or providers: (1) comply with the most recent Centers for _____ Control and Prevention (CDC) requirements for personal protective equipment (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 residents in Adult Mental Health and Treatment Facilities or forensic facilities 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), and their professional staff pursuant to subsection 744.361(14), Florida Statutes; H. Attorneys and their legal staff who are acting in their capacity as the legal representatives of residents where (a) the residents and lawyers are engaged in an active attorney-client relationships, (b) the visit is related to representation in legal proceedings or in consultation on legal matters, and (c) virtual or telephonic means are unavailable;	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 26 I. Representatives of the federal or state government seeking entry as part of their 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; J. Compassionate care visitors who meet the following definitions and satisfy the following criteria: i. Compassionate care visitors provide support, including emotional support, to help residents deal with difficult transition or loss, upsetting events, end-of-life situations, significant changes (such as recent admission to the facility), the need for assistance, cueing or encouraging with eating or drinking, or emotional distress or decline. ii. Regarding compassionate care visitors, the facility shall: 1. Establish policies and procedures for designation and utilizations of 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 residents and visitors, including evening and weekends, to accommodate work or childcare barriers; 4. Provide instructional signage throughout the facility and prevention and control education, including education on proper use of PPE, hygiene, and social	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 27 distancing; 5. Designate key staff to support prevention and control training; 6. Screen compassionate care visitors to prevent possible introduction of COVID-19; 7. Maintain a visitor log for signing in and out; 8. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing, especially for those who may have difficulty with compliance such as children; and 9. After attempts to mitigate concerns, restrict or revoke visitation if the compassionate care visitor fails to follow prevention and control requirements or other COVID-19-related rules of the facility. iii. Compassionate care visitors shall: 1. Wear a surgical mask and other PPE as appropriate. PPE for 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. Visit in the resident's room or in facility-designated visitation areas within the building; and 5. Maintain social distance of at least six with staff and other residents and limit movement in the facility except compassionate care visitors are not required to maintain social distance from the resident being visited. The facility may require compassionate care visitors to submit to facility-provided	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 28 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. K. General visitors, i.e. individuals other than 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. Wear a mask and perform proper hygiene; 2. Sign an acknowledgement form noting receipt and understanding of the facility's visitation and prevention and control policies. 3. Comply with facility-provided COVID-19 testing, if offered; 4. Visit in a resident's room or other facility-designated area; and 5. Maintain social distance of at least six feet with staff and residents, and limit movement	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 29 in the facility. iii. Before allowing general visitors, the facility shall: 1. Set a policy to 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, or with a resident at one time based on the ability of staff to safely screen and monitor visitation; 4. Establish limits on the length of visits, days, hours, and number of visits allowed per week; 5. Schedule visitors by _____ only; 6. Maintain a visitor log for signing in and out; 7. 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 prior ten (10) days tests positive for COVID-19; 8. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing; 9. Notify and inform residents and their representatives of any changes in the facility's visitation policy; 10. Clean and _____ visiting areas between visitors and maintain handwashing or sanitation stations; and 11. Designate staff to support _____ -prevention and control education of	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1300	Continued From page 30 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. The provisions of K.(1) (1) and (2) are not applicable to outdoor visitation. 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. Limit the number of visitors per resident at one 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. L. 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. ii. Barbers and salon staff must wear surgical masks, gloves, practice proper hygiene, and follow the same requirements as compassionate caregivers; iii. Waiting customers must follow social	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 31 distancing guidelines; . Residents receiving services must wear ... masks; v. Services are only provided to facility residents, not outside clients or guests; vi. Services may not be provided to a resident who tests positive for COVID-19 or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19; and vii. Service and salon areas must be properly cleaned and ... , and equipment must be sanitized between residents. 2. Individuals seeking entry to the facility, under the above section 1, will not be allowed to enter if they meet any of the screening criteria listed below: A. Any person ... with COVID-19 who does not meet the most recent criteria from the CDC to end isolation. 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 close contact with any person(s) known to be ... with COVID-19, who does not meet the most recent criteria from the CDC to end ... 3. 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. All facilities are encouraged to provide regular COVID-19 testing for staff and	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
NAME OF PROVIDER OR SUPPLIER KARELIS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 N.W. 8 AVE HOMESTEAD, FL 33030		
(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 32 visitors. 4. Any resident leaving the facility temporarily for medical , , or other activities, and any resident receiving visits from health care providers, must wear a mask, if tolerated by that 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. 5. 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. 6. 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 COVID-19 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	A1300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KARELIS HOME CARE LLC

**1536 N.W. 8 AVE
HOMESTEAD, FL 33030**

(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 33 failed to establish policies and procedures for for visitors during the SARS-CoV-2 pandemic. Findings as follow: Facility record review showed no COVID-19 Visitation policies and procedures available for review. On at 9.00 AM the Administrator stated Residents #1 and #2 received family visits. She she had explained to them the new policies regarding visits to residents in facility so they comply with the use of masks, six . distance, etc. She added she had not developed written policies but she knew she was putting it in practice. Class III	A1300		