Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969161	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLINA'S ALF LLC	28122 SW 160 CT HOMESTEAD, FL 33033

(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 complaint investigation (Complaints # 2020012640 & 2020011944) and a COVID-19 monitoring were conducted at Llina's ALF, LLC on , , and concluded on , . Deficiencies were identified at the time of survey.	A 000		
A 030 SS=G	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints 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	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 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 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.	A 030		

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A 030	Continued From page 2 (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened 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,	A 030		

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A 030	Continued From page 3 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (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 , , the guardian shall be given at least 45 days' notice of a nonemergency	A 030		

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A 030	Continued From page 4 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 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	A 030		

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A 030	Continued From page 5 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one out of three sampled residents lived in a safe and decent living environment, free from neglect for (Resident # 5). Resident # 5 received no medical care for seven days and was found to have three broken	A 030		

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A 030	Continued From page 6 ... only after being taken to the hospital by a family member. Findings included: A review of the facility's admission and discharge log revealed Resident #5 was admitted on and discharged on due to 'Family decision'. Record review showed a progress note describing that on Resident #5 got ..., while she was taking a shower with assistance of the caregiver (Staff B). The record said that 'Resident #5 almost ... but [Staff B] grabbed her around the waist to keep her from falling' and that probably the caregiver held the resident too hard, but the resident stated that she was fine. During a telephone interview with Resident #5's daughter on at 8:55 AM, she stated that during a visit she made to her mother on she noticed her mother was uneasy and had tremors. Her mother stated that her hurt. The daughter further stated that despite the social distance she approached her mother and lifted her blouse to find out her mother had a large ... on the left side from to waist. Immediately, she took her to the hospital where ... showed her mother had three broken ... and was positive for COVID-19. During an interview on at 11:04 AM, The Administrator stated that on ..., the caregiver (Staff B) was bathing Resident #5 who got ..., and almost ..., but the caregiver caught her before. The Administrator further stated that probably the ... was a consequence of the pressure when the caregiver held the resident.	A 030		

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A 030	Continued From page 7 The Administrator stated that she contacted the doctor who indicated that if the resident was not in , or not to take REsident #5 to the hospital, and due to age, it was normal for her skin to . The Administrator stated that Resident #5 told her that she was not in , . During an telephone interview on at 10:29 AM, Staff B stated that on the day of the incident, Resident #5 had just finished taking a bath when she almost , but she quickly grasped her (Staff B did not recall the exact date). Staff B further stated that after the incident, Resident #5 was fine and normal, only after a few days is that Resident #5 developed a on the side, under the arm, adding, "but that is only because elderly get easily." During an telephone interview on at 12:49 PM with the former caretaker (Staff D) she stated that Resident #5 never , and that what happened was that Staff B was bathing Resident #5 who got , but Staff B caught her before, so the might be because she was an old person and very skinny. Staff D stated that she was not present at the time of the occurrence. Staff D further stated that Resident #5 was breathing fine, but she had . Staff D stated that the could have occurred at that age because 'people are too fragile and if someone held them, they could get '. During a telephone interview on at 10:50 AM Resident #5 stated that she slipped in the shower and hit her side on a shower chair while taking a bath with the assistance of the caregiver (Staff B). She stated that it hurt a lot and she had told caregivers, but they did not take her to the hospital, they put an on her and gave her some pills, but it was still hurting.	A 030		

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A 030	Continued From page 8 Additionally, she tested positive for COVID-19 and felt really bad, had , chills, and a lot of , . Resident #5 said that only when her daughter came from another state was she taken to the hospital. A review of medical records showed that Resident #5 was admitted to the hospital on until . Further review of records revealed that upon admission to the hospital Resident #5 reported having , , , chills, , , and . Additionally, on her arrival at the hospital, saturation was at 91%. showed Resident #5 had of #6,7,8 and a small associated left-sided , . (According to Cleveland Clinic, a is a buildup of fluid between the layers of tissue that line the and , which can be caused by , , or injury). According to the hospital record, the resident also had a on the and a greenish discoloration on the . She needed , , and , precautions and was ordered a pureed diet. Additionally, the resident tested positive for COVID-19. Medical records revealed that Resident #5 also had diagnoses of , , , ( ), , , , , ( ) with , , and , , . In contrast, a review of the facility's records showed a Resident #5's Health Assessment completed on showing only diagnoses and medical history of cerebellar and . The resident needed precautions. The resident needed supervision in ambulation, eating, self-care (grooming), toileting and transferring; and needed assistance in	A 030		

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A 030	Continued From page 9 bathing, [redacted], and with the self-administration of medications. A review of the clinic record showed no documentation that a physician was contacted regarding the occurrence on [redacted]. The record showed that Resident #5's last contact with the clinic was on [redacted] for a medication refill. The record also showed that the resident's care with the clinic was closed out as of [redacted] with no further contact after the [redacted] medication refills. An [redacted] which had been scheduled for [redacted] was rescheduled. On [redacted] at 3:20 PM the Administrator stated that she did not believe the resident had three broken [redacted] as Resident #5 never expressed having any [redacted]. Class II	A 030		
A 077 SS=G	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	A 077		

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A 077	Continued From page 10 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., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements	A 077		

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A 077	Continued From page 11 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. (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	A 077		

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A 077	Continued From page 12 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 interview and record review, the facility failed to have an administrator capable of ensuring the provision of appropriate care to all residents. The facility was under a moratorium on admissions for two months due to several residents , an after being exposed to staff who did not follow guidelines from the Centers for Control. Six months after the moratorium, it was learned that three months prior to the outbreak at the facility, one out of three sampled residents was hospitalized after she was found to have multiple broken and being positive with COVID-19 (Resident #5). The resident received no medical care for seven days until a family member found , and discoloration on the resident's body. Findings included:	A 077		

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A 077	Continued From page 13 A review of the background screening database showed that the Administrator (Staff A) was the facility's administrator since . . . . . . Record review showed a progress note describing that on Resident #5 got . . . ., while she was taking a shower with assistance of the caregiver (Staff B). Then, Resident #5 almost . . but Staff B grabbed her around the waist to keep her from falling and that probably the caregiver held the resident too hard, but the resident stated that she was fine. During a telephone interview with Resident #5's daughter on . . . . . at 8:55 AM, she stated that during a visit she made to her mother on . . . . . she noticed her mother unease and trembling. Her mother stated that her hurt, and she saw . . . . , on her upper body. The daughter stated that staff told her that her mother almost . . a week before. Immediately, she took her to the hospital where , showed her mother had three broken . . and tested positive for COVID-19. The daughter stated that the facility did not inform the family when the incident happened. During an interview on at 11:04 AM, The Administrator stated that she contacted the doctor who indicated that if the resident was not in , or . . . . . not to take Resident #5 to the hospital, and due to age, it was normal of her skin to . . . . . The Administrator stated that Resident #5 told her that she was not in , . During a telephone interview on at 10:50 AM Resident #5 stated that she slipped in the shower and hit her side on a shower chair while taking a bath with the assistance of the caregiver (Staff B). The resident further stated	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969161	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 077	Continued From page 14 that she informed Staff B and the Administrator that she was in , , but they did not take her to the hospital. Instead, they put an on herand gave her some pills. However, the , did not cease and, she had had and chills since the . Additionally, she tested positive for COVID-19 and felt really bad, had , chills, and a lot of , . Only until her daughter came from another state is that she took her to the hospital. Record review showed the facility was under an imposed moratorium on admissions in , when all, but one resident tested positive for COVID-19 after staff had been exposed and continued to work without wearing appropriate personal protective equipment (PPE) to prevent cross- . A review of medical records showed that Resident #5 was admitted to the hospital on until . Further review of records revealed that upon admission to the hospital Resident #5 reported having , , , chills, , , and . Additionally, on her arrival at the hospital, , saturation was at 91%. , showed Resident #5 had of #6,7,8 and a small associated left-sided , . (According to Cleveland Clinic, a , is a buildup of fluid between the layers of tissue that line the and , which can be caused by , , or injury). Additionally, the resident tested positive for COVID-19. According to the hospital record, the resident also had a on the and a greenish discoloration on the . She needed , , and , precautions and was ordered a pureed diet. Medical records revealed that Resident #5 also	A 077		

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A 077	Continued From page 15 had diagnoses of [illegible] ( ), [illegible] ( ) with [illegible] and [illegible]. In contrast, a review of the facility's records showed a Resident #5's Health Assessment completed on showing only diagnoses and medical history of cerebellar and . The resident had indicated as special precautions. The resident was under a regular diet and condition status indicated that she did not have any [illegible], 3, or 4 . Resident #5 needed supervision in ambulation, eating, self-care (grooming), toileting and transferring; and needed assistance in bathing, and with the self-administration of medications. A review of the clinic record showed no documentation that a physician was contacted regarding the occurrence. The record showed that Resident #5's last contact with the clinic was on for a medication refill. The record also showed that the resident's care with the clinic was closed out as of with no further contact after the medication refills. An which had been scheduled for was rescheduled. Additionally, record review revealed that on , four months later after Resident #5 was injured, another resident (Resident #1) also while getting out of bed and had a On at 3:20 PM the Administrator confirmed that neither she or the facility's staff were a licensed health care provider to determine the residents' level of possible injury. The	A 077		

Agency for Health Care Administration

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A 077	Continued From page 16 Administrator stated that she did not believe the resident had three broken as Resident #5 never expressed having any , . . Class II	A 077		