

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 000}	Initial Comments A revisit to a re-licensure and a COVID-19 control survey was conducted at Maria Adult Home Care III on Deficiencies were identified at the time of the survey.	{A 000}			
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	{A 025}			

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: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 025}	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated written record of a significant change for one out of seven sampled residents (Resident # 1). Findings Include: In an interview on _____ at 11:20 AM, Staff C stated, "[Resident # 1] is bedridden. Someone from hospice comes once a day and bathes her. I then change her adult diapers throughout the day. She can't transfer on her own". Review of Resident # 1's records showed an	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARIA ADULT HOME CARE III

**14561 SW 30TH STREET
MIAMI, FL 33175**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 025}	Continued From page 2 outdated health assessment dated _____ with a medical history and diagnoses of _____, _____, and _____. Further review of the health assessment showed Resident # 1 needed assistance with all activities of daily living such as assistance, bathing, self - care (grooming), transferring, eating, toileting, and _____. Review of Resident # 1's hospice records showed Resident # 1 was referred to hospice on _____ and admitted to hospice on _____. Further review of hospice records showed an unsigned and undated health assessment with a medical history and diagnoses of Degenerative _____ of Nervous System, Poor vision, Generalized _____. The health assessment also showed Resident # 1 needed total care with all activities of daily living and had a _____. Further review of Resident # 1's progress notes showed no documentation of Resident # 1's significant changes such as the decline in health, hospice admission, and Resident # 1's _____. Class III Uncorrected	{A 025}		
{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	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 3 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 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.	{A 052}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 4 (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 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	{A 052}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 5 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 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	{A 052}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 6 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 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 seven sampled residents (Resident # 5).	{A 052}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021										
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175												
(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 7 Findings Include: Observation on at 2 PM showed Staff C washed her, unlocked Resident # 5's medication from the medication cabinet, popped a medication from the pack into a small cup and handed the cup to Resident # 5. Staff C stated to Resident # 5, "I'm going to give you your medication that is scheduled for 2 o'clock". Staff C did not state the name of the medication and dosage to Resident # 5. Review of Resident # 5's Medication Observation Record (MOR) showed the only medication scheduled for 2 PM was '..... 100mg Tab'. Review of Resident # 5's records showed no documentation of a written waiver to opt out of being orally advised of the medication name and dosage. Class III Uncorrected		{A 052}												
A 079 SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week <table> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td></td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> </table>		0-5	168		212	16-25	253	26-35	294	36-45	335	A 079		
0-5	168														
	212														
16-25	253														
26-35	294														
36-45	335														

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 079	Continued From page 8 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and _____ () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 079	Continued From page 9 considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 079	Continued From page 10 for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2021
NAME OF PROVIDER OR SUPPLIER MARIA ADULT HOME CARE III			STREET ADDRESS, CITY, STATE, ZIP CODE 14561 SW 30TH STREET MIAMI, FL 33175		
(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 079	Continued From page 11 agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have enough qualified staff available to provide resident supervision or arrange for resident services according to resident's scheduled and unscheduled needs for six out of seven sampled residents (Resident's # 1 - 5 & # 7). Findings Include: In an interview on _____ at 9:30 AM, Staff C stated that the current census were six residents and one resident is under hospice care. Staff B further stated that she was the only employee working at the facility because the Administrator was at a doctor's _____. Review of the facility's schedule for the month of _____ revealed Staff C was scheduled to work alone all-day Monday through Friday. Further review of the schedule also revealed the Owner was scheduled to work alone all day Saturdays and the Administrator to work alone all day Sundays.	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARIA ADULT HOME CARE III

**14561 SW 30TH STREET
MIAMI, FL 33175**

(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 079	Continued From page 12 Review of Resident # 1's records showed a health assessment undated and not signed by a health care professional; however, showed a medical history and diagnoses of Degenerative of the Nervous System. The health assessment also showed that Resident # 1 needed total care with all activities of daily living. In an interview on on 1:06 PM, Staff C stated, 'She went in hospice because she can't walk or get up. She's bedridden'. Review of Resident # 2's health assessment dated showed a medical history and diagnoses of Further review of the health assessment revealed Resident # 2 needed supervision with Ambulation, Bathing, and Self - Care (grooming). Resident # 2 also needed assistance with Toileting, and Transferring. Review of Resident # 3's health assessment dated showed a medical history and diagnoses of Status Post Resident # 3 needed precautions and needed supervision with Self - Care (grooming). Resident # 3 also needed assistance with Ambulation, Bathing, Toileting, and Transferring. Review of Resident # 4's health assessment dated showed a medical history and diagnoses of Resident # 4 needed precautions and needed assistance with all activities of daily living such as Ambulation, Bathing, Self - Care (grooming, Transferring,	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARIA ADULT HOME CARE III

**14561 SW 30TH STREET
MIAMI, FL 33175**

(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 079	Continued From page 13 Eating, _____, and Toileting. Review of Resident # 5's health assessment dated _____ showed a medical history and diagnoses of _____, and _____, Resident # 5 needed precautions and needed assistance with Bathing, _____, and Transferring. Review of Resident # 7's records revealed Resident # 7 was admitted on _____ and had no documentation of a health assessment. In an additional interview on _____ at 12:26 PM, Staff C stated, "I help bathe all the residents except for the one that is in hospice because hospice comes and bathes her in the morning. I then help them in going to the bathroom. [Resident # 2], [Resident # 3], [Resident # 4] need help with going to the bathroom. I give medications, I clean, and supervise them. [Owner] sometimes works with me. With [Resident # 7], I help her with going to the bathroom, she walks with her walker, she needs supervision with going to the bathroom, she can do everything else on her own". Class III	A 079		