

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969161</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/03/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LLINA'S ALF LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>28122 SW 160 CT</b><br><b>HOMESTEAD, FL 33033</b>                            |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 000}                                                    | Initial Comments<br><br>A revisit to a complaint investigation (Complaints # 2020012640 & 2020011944) and a COVID-19 monitoring was conducted at Llina's ALF, LLC on . . . . . Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {A 000}                                                                        |                                                                                                                          |  |                                                                    |
| {A 030}<br>SS=E                                            | 59A-36.007(6) FAC; 429.28( ) FS 429.27<br>Resident Care - Rights & Facility Procedures<br><br>59A-36.007<br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(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.<br>(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.<br>(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 | {A 030}                                                                        |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

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| {A 030}                                                    | Continued From page 1<br><br>and the text must be a minimum of 14-point font.<br>(d) The facility must have a written statement of<br>its house rules and procedures that must be<br>included in the admission package provided<br>pursuant to rule 59A-36.006, F.A.C. The rules<br>and procedures must at a minimum address the<br>facility's policies regarding:<br>1. Resident responsibilities;<br>2. _____ and tobacco use;<br>3. Medication storage;<br>4. Resident elopement;<br>5. Reporting resident _____, neglect, and<br>_____.<br>6. Administrative and housekeeping schedules<br>and requirements;<br>7. _____ control, sanitation, and universal<br>precautions; and,<br>8. The requirements for coordinating the delivery<br>of services to residents by third party providers.<br>(e) Residents may not be required to perform any<br>work in the facility without compensation.<br>Residents may be required to clean their own<br>sleeping areas or apartments if the facility rules<br>or the facility contract includes such a<br>requirement. If a resident is employed by the<br>facility, the resident must be compensated in<br>compliance with state and federal wage laws.<br>(f) The facility must provide residents with<br>convenient access to a telephone to facilitate the<br>resident's right to unrestricted and private<br>communication, pursuant to section 429.28(1)(d),<br>F.S. The facility must allow unidentified telephone<br>calls to residents. For facilities with a licensed<br>capacity of 17 or more residents in which<br>residents do not have private telephones, there<br>must be, at a minimum, a readily accessible<br>telephone on each floor of each building where<br>residents reside.<br>(g) In addition to the requirements of section | {A 030}                                                                        |                                                                                                                          |  |                                                                    |

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| {A 030}                                                    | <p>Continued From page 2</p> <p>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 _____.</p> <p>429.28 Resident bill of rights.-<br/>(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:</p> <p>(a) Live in a safe and decent living environment, free from _____ and neglect.</p> <p>(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> | {A 030}                                                                        |                                                                                                                          |  |                                                                    |

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| {A 030}                                                    | Continued From page 3<br><br>(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.<br>(g) Share a room with his or her spouse if both are residents of the facility.<br>(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.<br>(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.<br>(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.<br>(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 relocation or residency termination. Reasons for | {A 030}                                                                                       |                                                                                                                          |

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| {A 030}                                                    | Continued From page 4<br><br>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.<br><br>(1) 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.<br><br>(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 and identities of the residents involved in the | {A 030}                                                                                       |                                                                                                                          |  |                                                                    |

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| {A 030}                                                    | <p>Continued From page 5</p> <p>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.</p> <p>429.27 Property and personal affairs of residents.-</p> <p>(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.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that two out of seven sampled residents lived in a safe and decent living environment (Resident # 6 and # 7), free from</p> <p>Findings Include:</p> | {A 030}                                                                                       |                                                                                                                          |                                                                    |

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| {A 030}                                                    | Continued From page 6<br><br>Observation on _____ during a tour of the facility<br>showed a full side bed rail attached to a bed in<br># _____ and in # _____. At approximately 10<br>AM, the Administrator stated that Resident # 6<br>lived in # _____ and Resident # 7 lived in<br># _____.<br><br>In an interview on _____ at 10:12 AM, the<br>Administrator stated, "It's not hers (Resident # 6).<br>The bed had the rail already and I never took it<br>off. I can tell you now that I don't have the script".<br><br>In an interview on _____ at 11:31 AM, Staff D<br>stated, "Yes, at night we put it up for safety, so<br>she doesn't _____.<br><br>Review of Resident # 6's records showed an<br>admission date of _____ and showed no<br>documentation of a prescription from a health<br>care provider ordering a full side bed rail for<br>Resident # 6.<br><br>Review of Resident # 7's records also showed an<br>admission date of _____ and showed a<br>prescription from a health care provider for a half<br>side bed rail.<br><br>Class III<br>Uncorrected | {A 030}                                                                                       |                                                                                                                          |  |                                                                    |
| {A 077}<br>SS=G                                            | 429.176 FS; 429.52( _____ ), 59A-36.01(1) FAC<br>Staffing Standards - Administrators<br><br>429.176 Notice of change of administrator.-If,<br>during the period for which a license is issued,<br>the owner changes administrators, the owner<br>must notify the agency of the change within 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {A 077}                                                                                       |                                                                                                                          |  |                                                                    |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969161</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/03/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LLINA'S ALF LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>28122 SW 160 CT</b><br><b>HOMESTEAD, FL 33033</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {A 077}                                                    | <p>Continued From page 7</p> <p>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.</p> <p>429.52<br/>(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.</p> <p>(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.</p> <p>59A-36.010<br/>(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.</p> <p>(a) An administrator must:</p> <ol style="list-style-type: none"> <li>1. Be at least _____;</li> <li>2. If employed on or after _____, have, at a minimum, a high school diploma or G.E.D.;</li> <li>3. Be in compliance with Level 2 background</li> </ol> | {A 077}                                                                                       |                                                                                                                          |                                                                    |



Agency for Health Care Administration

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| {A 077}                                                    | Continued From page 8<br><br>screening requirements pursuant to sections 408.809 and 429.174, F.S.;<br>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,<br>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.<br>(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:<br>1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,<br>2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.<br>(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 | {A 077}                                                                                       |                                                                                                                          |                                                                    |

Agency for Health Care Administration

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| {A 077}                                                    | <p>Continued From page 9</p> <p>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.</p> <p>(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.</p> <p>(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: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09393">http://www.flrules.org/Gateway/reference.asp?No=Ref-09393</a>.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an administrator capable of ensuring the provision of appropriate care to all residents. The facility received a Class I citation for a resident receiving no medical care for seven days after falling and staff were still not trained on what to do in the event of a _____.</p> <p>Findings Include:</p> | {A 077}                                                                                       |                                                                                                                          |

Agency for Health Care Administration

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| {A 077}                                                    | <p>Continued From page 10</p> <p>Review of the facility's survey history revealed the facility was cited a Class I for Resident Care - Rights &amp; Facility Procedures from a complaint investigation on ..... through .....</p> <p>Review of the facility's correction plan dated ..... showed "We understand that after the prevention of the ..... the Resident could have been seen by a medical doctor yet because there was no physical ..... and the Resident was not complaining of any ..... or discomfort the staff monitored her closely in order to secure that she was OK. Due to the response, we had in the facility we understood that reviewing the policies and procedures in order to meet criteria and be in compliance with the protocol was imperative therefore we have done so. Furthermore, we have ..... with a consultant in order to supervise our facility, retrain, and assist with compliance". [sic]</p> <p>Review of the facility's training records showed no documentation staff were properly trained or retrained on what to do in the event of a ..... There was also no documentation the facility had ..... consultant services.</p> <p>In an interview on ..... at 1 PM, the Administrator stated, "We don't have the trainings yet. The consultant is coming in the next week or so to provide us the training and give us the certificates".</p> <p>Class III<br/>Uncorrected</p> | {A 077}                                                                                       |                                                                                                                          |