

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANNY'S GARDEN HOME ALF, LLC

**11173 SW 112 STREET
MIAMI, FL 33176**

(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 An Abbreviated Re-Licensure with COVID-19 Monitoring Survey was conducted at Granny's Garden Home ALF, LLC. on _____ to _____. Deficiencies were identified at the time of survey.	A 000		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative _____ examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of _____ testing materials satisfies the annual _____ examination requirement. An individual with a positive _____ test must submit a health care provider's statement that the individual does not constitute a risk of _____. 2. If any staff member has, or is suspected of having, a communicable _____, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable _____.	A 078		

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: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of two sampled staff, (Staff A) was able to perform assigned duties consistent with training. The staff was not aware of all residents who had a valid () and did not know	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 078	Continued From page 2 what to do if a resident became unresponsive. Findings included: 1) Review of Staff A's record showed a hire date of _____ with a _____ training dated _____. On _____, at 1:30 PM, when asked what _____ was, Staff A stated, "That is the yellow paper, it means not to _____ the resident. I do not know who has one here." Review of all resident's records showed that Residents # 2 and 4 had a _____ on record. 2) Review of Staff A's record showed a current First Aid and _____ training dated _____. On _____, at 1:30 PM, Staff A stated, "If there is an emergency, and someone is unresponsive, I call 911. I do not know what to do after that." Class III	A 078			
A 190 SS=D	59A-36.023() & (3)(b); 429.14() Administrative Enforcement 59A-36.023() & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429,	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 3 F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 58A-5.0181, F.A.C., relating to residency criteria;	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 4 2. Section 429.27, F.S., and Rule 58A-5.021, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 58A-5.0182, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 58A-5.0182, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for _____ and transportation to _____; 5. Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 58A-5.019, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 58A-5.020, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 58A-5.029, F.A.C., relating to mental health residents' community support living plan; 9. Section 429.07, F.S., and Rule 58A-5.030, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 58A-5.031, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted:	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 5 - Violations of Rule Chapter 69A-40, F.A.C., relating to fire safety, that threaten the life or safety of a resident; - Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; - Violations relating to facility staff rendering services for which the facility is not licensed; or - Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: - A description of the deficiency; - A citation to the statute or rule violated; and - A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3(b) Dietary Deficiencies. - If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 58A-5.020, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 6 the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial on-site consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on observation, record review and	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 7 interview, the facility incorrectly reported events regarding an adverse incident. Findings included: Record review of the facility's adverse incidents reported showed that on 7/13/2021 at around 10:30 AM Resident #1 was outside on the driveway in front of the house with the owner getting some fresh air and sun, when all of a sudden the resident got up, lost his balance and fell towards his right side. The report further stated that immediately, the Owner assisted Resident #1 to make sure he was responsive as she was calling 911. The report stated that Rescue arrived at about 10:45 AM and transported the resident to the hospital. A review of the Emergency Medical Services (EMS) record showed " Upon arrival found (patient) and an ALF who escaped from the home and tripped outside and fell to the ground striking his head on the pavement. EMS takes (a resident) and was unable to get an adequate response from the resident despite a history of falls. alert to [] " Interviewed on 7/13/2021, Resident #1's relative stated by telephone, "I understand he got up from the sofa, walked to the front door, opened the door, and went outside, and fell on the sidewalk. He fell around 6:00 pm. I understand he fell before noon. It might have been a neighbor who noticed him on the sidewalk. " On 7/13/2021 at 10:15 AM, the Owner stated, "When I didn't see him, I walked and I saw the door was closed but not with the lock, the door alarm sounded. He was on the couch in the Florida room. Three doors have alarms. I never	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANNY'S GARDEN HOME ALF, LLC

**11173 SW 112 STREET
MIAMI, FL 33176**

(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 190	Continued From page 8 expected him to walk like that. He was on the floor, he was talking. He had ." On at 11:05, Neighbor #1 stated, "I was walking my dog with my child, and I saw the man getting out the house, . on the ground; I did not want to touch him, so I knocked on the door; a woman was cleaning the windows, and another opened the door; she kept telling me that she had no idea how he got out of the house. The rescue came immediately. The owner was not at the house, she has a red car, the one you see there; that car was not there that day. The neighbors of this house got out also. It was around 10:00 am." On at 11:05, Neighbor #1 stated "I was at home with my grandson, we went out. The man was alone, no one from the house was outside. I was with my grandson, and he called 911." On at 10:48 AM, the Owner stated regarding Resident #1, "He was in the Florida room on the sofa, got up, and started walking without his walker, and . in front of the main entrance door." On at 11:50 AM, the owner showed the video from her old phone. Observed the resident who was sitting in a recliner located at the Florida room, got up, walked to the front door, opened the door, and got out. On at 5:15 PM, the Owner stated, "The consultant is the one doing the form online; I need to learn how to do it. I used to do it when it was manually done on paper."	A 190		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 9 Class III	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANNY'S GARDEN HOME ALF, LLC

**11173 SW 112 STREET
MIAMI, FL 33176**

(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 An Abbreviated Re-Licensure with COVID-19 Monitoring Survey was conducted at Granny's Garden Home ALF, LLC. on _____ to _____. Deficiencies were identified at the time of survey.	A 000		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative _____ examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of _____ testing materials satisfies the annual _____ examination requirement. An individual with a positive _____ test must submit a health care provider's statement that the individual does not constitute a risk of _____. 2. If any staff member has, or is suspected of having, a communicable _____, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable _____.	A 078		

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: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of two sampled staff, (Staff A) was able to perform assigned duties consistent with training. The staff was not aware of all residents who had a valid () and did not know	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 078	Continued From page 2 what to do if a resident became unresponsive. Findings included: 1) Review of Staff A's record showed a hire date of _____ with a _____ training dated _____. On _____, at 1:30 PM, when asked what _____ was, Staff A stated, "That is the yellow paper, it means not to _____ the resident. I do not know who has one here." Review of all resident's records showed that Residents # 2 and 4 had a _____ on record. 2) Review of Staff A's record showed a current First Aid and _____ training dated _____. On _____, at 1:30 PM, Staff A stated, "If there is an emergency, and someone is unresponsive, I call 911. I do not know what to do after that." Class III	A 078			
A 190 SS=D	59A-36.023() & (3)(b); 429.14() Administrative Enforcement 59A-36.023() & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429,	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 3 F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 58A-5.0181, F.A.C., relating to residency criteria;	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANNY'S GARDEN HOME ALF, LLC

**11173 SW 112 STREET
MIAMI, FL 33176**

(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 190	Continued From page 4 2. Section 429.27, F.S., and Rule 58A-5.021, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 58A-5.0182, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 58A-5.0182, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for _____ and transportation to _____; 5. Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 58A-5.019, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 58A-5.020, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 58A-5.029, F.A.C., relating to mental health residents' community support living plan; 9. Section 429.07, F.S., and Rule 58A-5.030, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 58A-5.031, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted:	A 190		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 5 - Violations of Rule Chapter 69A-40, F.A.C., relating to fire safety, that threaten the life or safety of a resident; - Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; - Violations relating to facility staff rendering services for which the facility is not licensed; or - Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: - A description of the deficiency; - A citation to the statute or rule violated; and - A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3(b) Dietary Deficiencies. - If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 58A-5.020, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 6 the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial on-site consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on observation, record review and	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176		
(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 190	Continued From page 7 interview, the facility incorrectly reported events regarding an adverse incident. Findings included: Record review of the facility's adverse incidents reported showed that on 7/13/2021 at around 10:30 AM Resident #1 was outside on the driveway in front of the house with the owner getting some fresh air and sun, when all of a sudden the resident got up, lost his balance and fell towards his right side. The report further stated that immediately, the Owner assisted Resident #1 to make sure he was responsive as she was calling 911. The report stated that Rescue arrived at about 10:45 AM and transported the resident to the hospital. A review of the Emergency Medical Services (EMS) record showed " Upon arrival found (patient) and an ALF who escaped from the home and tripped outside and fell to the ground striking his head on the pavement. EMS takes (a resident) and was unable to get an adequate response from the resident despite a history of falls. alert to [] " Interviewed on 7/13/2021, Resident #1's relative stated by telephone, "I understand he got up from the sofa, walked to the front door, opened the door, and went outside, and fell on the sidewalk. He fell around 6:00 pm. I understand he fell before noon. It might have been a neighbor who noticed him on the sidewalk. " On 7/13/2021 at 10:15 AM, the Owner stated, "When I didn't see him, I walked and I saw the door was closed but not with the lock, the door alarm sounded. He was on the couch in the Florida room. Three doors have alarms. I never	A 190			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRANNY'S GARDEN HOME ALF, LLC

**11173 SW 112 STREET
MIAMI, FL 33176**

(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 190	Continued From page 8 expected him to walk like that. He was on the floor, he was talking. He had ." On at 11:05, Neighbor #1 stated, "I was walking my dog with my child, and I saw the man getting out the house, . on the ground; I did not want to touch him, so I knocked on the door; a woman was cleaning the windows, and another opened the door; she kept telling me that she had no idea how he got out of the house. The rescue came immediately. The owner was not at the house, she has a red car, the one you see there; that car was not there that day. The neighbors of this house got out also. It was around 10:00 am." On at 11:05, Neighbor #1 stated "I was at home with my grandson, we went out. The man was alone, no one from the house was outside. I was with my grandson, and he called 911." On at 10:48 AM, the Owner stated regarding Resident #1, "He was in the Florida room on the sofa, got up, and started walking without his walker, and . in front of the main entrance door." On at 11:50 AM, the owner showed the video from her old phone. Observed the resident who was sitting in a recliner located at the Florida room, got up, walked to the front door, opened the door, and got out. On at 5:15 PM, the Owner stated, "The consultant is the one doing the form online; I need to learn how to do it. I used to do it when it was manually done on paper."	A 190		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER GRANNY'S GARDEN HOME ALF, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11173 SW 112 STREET MIAMI, FL 33176			
(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 190	Continued From page 9 Class III	A 190			