Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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<br><br>An unannounced Relicensure, Generator Assessment and Focused Control survey was conducted on at Wellness Living in Plantation, LLC. The facility had deficiencies related to the Relicensure at the time of the survey. | A 000 | | |
| A 032 | 59A-36.007(8) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(8) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.<br>1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.<br>2. The facility must have a photo identification of | A 032 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 032 | Continued From page 1<br><br>at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.<br>(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that all staff participated in the required elopement drills annually, for 3 out of 4 staff (Staff B, C and D).<br><br>The findings included: | A 032 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 032 | Continued From page 2<br><br>On at 3:58PM upon request, Staff A (Owner) provided an agenda record for the elopement drills conducted for the years 2019 and 2020 at the facility. Review of the documentation provided does not have the names of the employees participated. There was not an sign-in sheet that accompanied the agenda. At this time, the Administrator was provided an opportunity to locate additional documentation.<br><br>At 4:10PM, Staff A provided another elopement drills record conducted on and without a sign-in sheet, review of the documentation revealed that there no documentation that staff B, C and D participated in at least two elopements drills for the year 2019 and 2020.<br><br>During an interview with the Owner on at approximately 4:14PM, no additional documentation was provided, and she acknowledge the findings.<br><br>Class III | A 032 | | |
| A 054 | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. | A 054 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 054 | Continued From page 3<br><br>(b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include:<br>1. The name of the resident and any known [illegible] the resident may have;<br>2. The name of the resident's health care provider and the health care provider's telephone number;<br>3. The name, strength, and directions for use of each medication; and,<br>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the Assisted Living Facility failed to ensure the accuracy of medication based on observation, interview and record review, the facility failed to ensure that the Medication Observation Records (MOR) are accurate and updated immediately by the staff after medication assistance was provided to the resident, for 2 out of 4 residents (Resident #2 and #4).<br><br>The findings included:<br><br>At 9:05AM after entering the facility, this surveyor asked Staff B (HHA) the time for med pass; Staff B stated that she has already given morning medication to Residents 1, 2, 3, and 4 and did not | A 054 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 054 | Continued From page 4<br><br>have a chance to update the MOR. Staff B (HHA) picked up the MOR book and updated the records.<br><br>At 1:30PM during review of the MOR's, in the presence of staff A (Owner), the following errors were identified:<br><br>1) Resident #2<br>AM doses for 400mg 3 times a week were not updated for for Monday , Wednesday and Friday . 5mg 1 tablet daily was not updated for Friday .<br><br>2) Resident #4<br>PM Doses for , 10mg 1 tablet at bedtime was documented as already given on at AM medpass.<br>At this time, the Owner acknowledged the findings and no additional information was provided.<br><br>Class III | A 054 | | |
| A 055 | 59A-36.008(6) FAC Medication - Storage and Disposal<br><br>(6) MEDICATION STORAGE AND DISPOSAL.<br>(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out | A 055 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 055 | Continued From page 5<br>of sight of other residents.<br>(b) Both prescription and over-the-counter medications for residents must be centrally stored if:<br>1. The facility administers the medication;<br>2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;<br>3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;<br>4. The resident fails to maintain the medication in a safe manner as described in this paragraph;<br>5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or<br>6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C.<br>(c) Centrally stored medications must be:<br>1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;<br>2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;<br>3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to | A 055 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 055 | Continued From page 6<br><br>the medication storage areas at all times; and,<br>4. Kept separately from the medications of other residents and properly closed or sealed.<br>(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.<br>(e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).<br>(f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.<br>(g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the Assisted Living Facility failed to ensure that medication cart is locked and secured | A 055 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 055 | Continued From page 7<br>at all times.<br><br>The findings included:<br><br>On ..... at 10:46 at the end of facility tour, this surveyor observed the medication cart unlocked with keys hinging on the side lock. The medication cart is stored in the dining room in the corner between the patio door and the large entrance to the common area at arm distance to the dining table; where residents pass through to go to the patio. At 3:30PM in the presence of Staff A (Owner), this surveyor opened the draws of the medication cart revealing that the cart was not locked. Also observed a small, unlocked refrigerator on top of the cart. When opened, observed there are medications/drugs inside the refrigerator. At this time, at 3:30PM, interview with Staff A revealed that the small refrigerator has medications that need to be disposed of. Staff A stated that the cart should not be unlocked.<br><br>At 10:06AM observed Resident #3 eating snack at the dining table approximately 5ft from the Medication cart. At 12:46PM observed Resident #1 approached next to the unlocked medication cart with key in it, picking up cat food and went outside to feed the cat. Medication Cart remained unlock and unattended approximately 2 ft from this surveyor until the surveyor left the facility.<br><br>At 4:35PM during exit interview Staff A, stated that she will lock Medication cart and remove the keys and acknowledge the findings.<br><br>Class III | A 055 | | |
| A 083 | 59A-36.011(5) FAC Training - First Aid and | A 083 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 083 | Continued From page 8<br><br>(5) FIRST AID AND . . . . . ( ). 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.<br>(a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.<br>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure a staff member who has completed and holds a currently valid card for First Aid and . course is in the facility at all times, for 2 out 3 sampled staff records reviewed (staff A and C)<br><br>The findings included:<br><br>On . . . . . at 2:20PM, the facility staff schedule was requested from Staff A (Owner) and was provided dated . . . . . and . . . review of the staffing schedule revealed the facility has a 24 hours shift for 4 days and 3 days rotating every other week: Staff | A 083 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 083 | Continued From page 9<br><br>B (HHA) work 4 days then Staff C (HHA) work 3 days.<br><br>On at approximately 2:30PM, a review of personnel records revealed the First Aid and card for Staff A expired on of and First Aid and card for Staff C expired on . At this time, Staff A was provided an opportunity to locate the documentation. At approximately 4:35PM, during exit interview Staff A provided, no additional documentation and acknowledge the findings.<br><br>Class III | A 083 | | |
| A 161 | 429.275(2) FS; 59A-36.015(2) FAC Records - Staff<br><br>429.275<br>(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.<br><br>59A-36.015<br>(2) STAFF RECORDS.<br>(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: | A 161 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 161 | Continued From page 10<br><br>1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C.,<br>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,<br>3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C.,<br>4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C.,<br>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.<br>(b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ␣ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C.<br>(c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure all staff had a signed employment application on file, for 1 of 3 sampled staff (Staff C).<br><br>The findings included: | A 161 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969123 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WELLNESS LIVING IN PLANTATION LLC | 221 NW 49TH AVE PLANTATION, FL 33317 |

| (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 161 | Continued From page 11<br><br>An employee record review was completed for Staff C (HHA) whose hire date was [redacted], revealed Staff C did not have a signed employment application on file. At this time, Staff A (Owner) was provided an opportunity to locate the documentation.<br><br>During an interview with the Owner on [redacted] at approximately 2:35PM, no additional documentation was provided, and she acknowledge the findings.<br><br>Class | A 161 | | |