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
	AL11953247	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMA HOME CARE INC	13720 SW 108 STREET MIAMI, FL 33186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey was conducted at Ama Home Care Inc on [redacted] & [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making [redacted] and remind residents about scheduled [redacted] for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a [redacted] health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assist a resident with arrangement for healthcare services for one out six (Resident #6) sampled residents. Resident #6 needed to see a [redacted] in one or two weeks after being discharged from the hospital. Findings Included: A review of Resident's #6 hospital record revealed the resident was admitted on [redacted] with generalized malaise, body aches and [redacted]. The patient had a Hypertensive crisis, Hyperkalemia, [redacted]	A 027		

AHCA Form 3020-0001

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

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A 027	Continued From page 1 ..., Lower ..., ..., severe COVID, in with .... The patient was discharged to the facility on . The discharged record showed the resident needed to follow up with a ... interventionist in one or two weeks. A review of Resident # 6's record revealed he was admitted to the facility on ... . The health assessment done on showed the resident was diagnosed with ... ..., ..., ..., ..., ..., ..., Mild ..., ..., and Gait .... The physician indicated the resident needed supervision with ... and eating and assistance with the rest of the activities of daily living. Progress note revealed the resident was transferred to the hospital with ..., ... and arm ..., on ... . Resident returned to the facility on ... . There was no documentation that the facility assisted the resident to see a ... after the discharge from the hospital on . On at 12:55 PM, the Manager stated Resident #6's ..., ..., ..., ..., last year, and he refused to be seen by another one. The Manager confirmed the facility did not have documentation of the resident's refusal to see a ... On ... at 1:18 PM, Resident's #6 sister stated, "My brother, ..., today. He had three ... and COVID-19 last year. His ..., ..., last year from COVID-19. He refused to be seen by another ..." On at 1:34 PM, Resident #6's	A 027		

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A 027	Continued From page 2 physician stated he saw the resident only one time because he was at the hospital every time the physician he visited the facility. He said that the resident was very sick, and that he was a heavy smoker who was supposed to be seen by a Class II	A 027		