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
	AL11953342	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HOME ALF INC	447 EAST 26 STREET HIALEAH, FL 33013

(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 Professional Home ALF, Inc. on , . Deficiencies were identified at the time of survey.	A 000		
A 033 SS=D	59A-36.007(8) PHYSICAL . (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have a Plan of care for the use of physical for Resident 2.	A 033		

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A 033	Continued From page 1 Findings included: On [redacted] at [redacted] at 10:05 AM, observed Resident 2's bed with full bed rails attached to it. Review of Resident 2's record showed the resident did not have a plan of care for the use of full bed rails signed by the physician. On [redacted] at 1:08 PM, the Administrator stated, "The problem with this is that I forgot to give it to him." Class III	A 033		
A 123 SS=D	429.27( ) FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless	A 123		

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A 123	Continued From page 2 upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident. (5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies. 59A-36.013 (2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or	A 123		

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A 123	Continued From page 3 due a resident, including personal funds, must be held as trust funds and expended only for the resident's account. Resident funds or property may be held in one bank account if a separate written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide proof of a statement at least once every three months, detailing sources and disposition of funds with their correspondent receipts for all purchases made with Resident 4's , , , ( ). Findings included: Review of Resident 4's records showed a log with monthly amount received of initialed by the resident and staff. The resident was a recipient of . The Administrator acknowledged that the money was received at the facility and belonged to the resident, and that she would buy items for the resident, but was not keeping the receipts. On , , at 2:10 PM, the administrator stated, "Here, these are the cigarettes I purchase for him with his ; I am not keeping a log of the purchases, or the receipts, but I will start doing it right away." Class III	A 123		

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A 162	Continued From page 4	A 162		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually.	A 162		

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A 162	Continued From page 5 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ... ( ), CF-ES 1006, , , . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	A 162		

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A 162	Continued From page 6 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020,	A 162		

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A 162	Continued From page 7 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide proof of a prescription for full bed rails for Resident 2. The resident was receiving hospice care, and had full bed rails attached to the bed. Findings included: On , at 10:05 AM, observed Resident 2's bed with full bed rails attached to it. The staff stated, the resident was receiving hospice care. Review of the facility's record for Resident 2, and the hospice record showed no full bed rails prescription. On , at 2:00 PM, the Administrator stated, "I don't understand why we don't have it on the record of the resident, or the hospice one. I will talk to them as soon as possible." Class III	A 162		