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
	AL11966205	A. BUILDING: _____ B. WING _____	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE INC.	11412 NW 1ST PLACE CORAL SPRINGS, FL 33071

(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 unannounced Relicensure, Complaint (#2020007704) and Generator Monitoring survey was conducted on and at Care Inc. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 083	59A-36.011(5) FAC Training - First Aid and (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. (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. (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. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that First Aid/or ( ) was valid and current for two 2 of 2 employees reviewed (Administrator and Staff A).	A 083		

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
	AL11966205	A. BUILDING: _____ B. WING _____	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE INC.	11412 NW 1ST PLACE CORAL SPRINGS, FL 33071

(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 1 The findings included: A review of the Administrator files and documents revealed a date of hire of and that she works alone during the 7:00 AM - 7:00 AM shift and provides direct care to residents. Review of the Administrator's facility file revealed the Administrator's most recent First Aid certificate from the American Association First Aid/ / certificate was dated - In an interview conducted with the Administrator on at 11:10 AM, she was informed that the most recent First Aid certificate in her file had expired. She stated she had just taken the class and has it and provided a certificate for Basic Life Support (BLS). This Surveyor explained that BLS is not the same as First Aid. She stated she would reach out to the provider regarding it. A review of Home Health Aide Staff A facility file and documents revealed she was hired on , provides direct care to staff and who works during the 7:00 AM - 7:00 AM shift. Review of her file also revealed she did not have a valid and current certification in her file. Review of her file also revealed a certificate from the American Association with an expiry date of . Further there was no evidence of a First Aid certificate. In an interview conducted with the Administrator on at 1:56 PM, she was informed that Staff A's file did not contain a current certificate and that the most recent one expired . She reviewed the file and was not able	A 083		

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
	AL11966205	A. BUILDING: _____ B. WING _____	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE INC.	11412 NW 1ST PLACE CORAL SPRINGS, FL 33071

(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 2 to locate one. In an interview with the Administrator on at 2:28 PM she stated she overlooked it but will have her get it. During an interview conducted on at 1:42 PM, the Administrator acknowledged the findings. Class III	A 083		