

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969432</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/23/2022</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**PEACE OF HIS CORNERSTONE LLC**

**605 NE 160 ST  
MIAMI, FL 33162**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A re-licensure survey was conducted at Peace of His Cornerstone, LLC on . A deficiency was identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A 000               |                                                                                                                          |                          |
| A 085<br>SS=D            | 59A-36.011(7) FAC Training - Nutrition & Food Service<br><br>(7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietitian, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service.<br><br>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure two out of two sampled staff members (Administrator and Staff B), who are a person designated for the facility's food service, obtained a minimum of 2 hours of continuing education in topics pertinent to nutrition and food service by a certified food manager, licensed dietitian, registered dietary technician or health department sanitarian.<br><br>Finding includes:<br><br>Review of Administrator's personnel records revealed a training on two hours of nutrition and food service dated . Further review | A 085               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
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|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 085                    | <p>Continued From page 1</p> <p>showed the training was conducted by the administrator, who is not a certified food manager, licensed dietitian, registered dietary technician or health department sanitarian.</p> <p>Review of Staff B's personnel records revealed a training on two hours of Nutrition and Food Service dated . Further review showed the training was conducted by the administrator, who is not a certified food manager, licensed dietitian, registered dietary technician or health department sanitarian.</p> <p>On at 11:10 AM, Administrator stated, "I can take the training today."</p> <p>Class III</p> | A 085               |                                                                                                                          |                          |