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 |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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>A biennial re-licensure survey, with a limited menatl heath component, was conducted at Mariluca # 2 on . Deficiencies were identified at the time of the survey. | A 000 | | |
| A 054 SS=D | 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.<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 . . . . . 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 . . . . . , 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. | A 054 | | |

AHCA Form 3020-0001

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

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 |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 1<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that the medication observation record (MOR) was immediately updated each time the medication is offered or administered for one out of six (Resident #4) sampled residents.<br><br>Findings included:<br><br>On at 09:05 AM, Staff D stated that she administered medications to all the residents who needed assistance with self-administration of medications.<br><br>Review of Resident #4's MOR showed the 09:00 AM medication, Rosuvastatin 10 MG, was last initialed on , and the 08:00 PM medication, 30 MG, was last initialed on .<br><br>On at around 02:20 PM, the Owner stated, "It was not initialed for today. I will look at it and make sure it's updated."<br><br>Class III | A 054 | | |
| A 078 SS=D | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff | A 078 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 078 | Continued From page 2<br>does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . .<br>2. If any staff member has, or is suspected of having, a communicable . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable .<br>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.<br>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.<br>(d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to | A 078 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 078 | Continued From page 3<br><br>perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,<br>2. Maintain time sheets for all staff.<br>(f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to have a written statement from a health care provider documenting that the staff does not have any signs or symptoms of communicable for one out of six staff (Administrator) sampled staff..<br><br>Findings included:<br><br>Review of Administrator's personnel record showed a hired date of . There was no written statement from a health care provider documenting that the staff does not have any signs or symptoms of communicable . . . . . in file.<br><br>On at 02:20 PM, the Owner stated, "Oh, he (Administrator) has it. I don't know why we don't have a copy here, but I'll have him bring a copy."<br><br>Class III | A 078 | | |

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 |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 080 | Continued From page 4 | A 080 | | |
| A 080 SS=D | 429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test<br><br>429.52<br>(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.<br>(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:<br>(a) State law and rules relating to assisted living facilities.<br>(b) Resident rights and identifying and reporting , neglect, and .<br>(c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs.<br>(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.<br>(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.<br>(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.<br>(g) Care of persons with 's and related .<br><br>59A-36.011 | A 080 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 080 | Continued From page 5<br>(1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.<br>(a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.<br>(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , and managers who attended the core training program prior to , , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement.<br>(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years.<br>(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:<br>1. Retake the assisted living facility core training; and,<br>2. Retake and pass the competency test. | A 080 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 080 | Continued From page 6<br><br>(e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that the administrator successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator.<br><br>Findings included:<br><br>Review of Administrator's personnel record showed the administrator was hired on . Further review showed the administrator completed the minimum 26 hours of training requirements; however, there was no documentation of a successful passing score or certification of the competency test.<br><br>On at 01:10 PM, Owner stated, "He (Administrator) doesn't have the CORE yet. He took the 26-hour class, but they don't offer the exam until the end of this month. We are scheduled to take the exam on , we both [Administrator] and I."<br><br>Class III | A 080 | | |
| A 082 SS=D | 59A-36.011(4) FAC Training - /<br><br>(4) | A 082 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 082 | Continued From page 7<br><br>( / ), Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure staff received / ( / ) training for one out of four (Staff B) sampled staff.<br><br>Findings included:<br><br>Review of Staff B's personnel record showed a hired date on . Further review showed no documentation of / training.<br><br>On at around 02:20 PM, the Owner stated, "she [Staff B] has it. I don't know where it is right now, but I will find it. She's being working in ALF for years."<br><br>Class III | A 082 | | |
| A 161 SS=D | 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 | 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 |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 8<br><br>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:<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 | A 161 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 9<br>. . . . . , 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 record review and interview, the facility failed to maintain personnel records for each staff member which contain a copy of the employment application with references and copy job description for staff ( Administrator and Staff B).<br><br>Findings included:<br><br>Review of Administrator's personnel record revealed Administrator was hired on . Further review showed Administrator had a job application with no references listed. There was no job description in file.<br><br>Review of Staff B personnel record revealed a hired date on . There was no employment application in file.<br><br>On . . . . . at around 02:20 PM, the Owner stated, "That's my mistake. I should have seen that [Administrator] job description wasn't in file. As far as the references, I'll get the references for everyone (the staff).".<br><br>Class III | A 161 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 162 | Continued From page 10 | A 162 | | |
| A 162 SS=D | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. [illegible],<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance [illegible],<br>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,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(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.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 162 | Continued From page 11<br>(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.<br>(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.<br>(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.<br>(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.<br>(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.<br>(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.<br>(m) Documentation of the , , of a health care surrogate, health care proxy, | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 162 | Continued From page 12<br>guardian, or the existence of a power of attorney, where applicable.<br>(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.<br>(o) The resident's . . . . . , DH Form 1896, if applicable.<br>(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:<br>1. A log listing the names of residents participating in this arrangement,<br>2. The resident demographic data required in this paragraph,<br>3. The health assessment described in rule 59A-36.006, F.A.C.,<br>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,<br>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.<br>(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.<br>(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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 162 | Continued From page 13<br>59A-36.021 and 59A-36.022, F.A.C., respectively.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to maintain a complete and accurate health assessment for two out of six sampled residents (Resident #1 and Resident #3).<br><br>Findings included:<br><br>Observation on . . . at around 08:45 AM showed Resident #1 and Resident #3 were in bed with full bedrails in upright position.<br><br>Review of Resident #2's health assessment dated showed the resident was under hospice care and needed assistance with all activities of daily living including ambulation, bathing, , eating, self-care (grooming), toileting, and transferring.<br><br>Review of Resident #3's health assessment dated . . . . . showed the resident was under hospice care and needed total care with all activities of daily living including ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. Further review showed the special precautions was left empty, and the section D of the health assessment was left unchecked.<br><br>On at 10:25 AM, Owner stated, "Resident #3 needs total care in some activities and assistance in some other stuffs. For example, she needs assistance with eating, medications, and ambulation. Resident #1 on the other needs total care with everything. I don't know why the doctor did the health | A 162 | | |

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 |
|---|---|---|---|
| | AL11964209 | A. BUILDING: _____ B. WING _____ | 05/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARILUCA # 2 | 9362 SW 155 AVENUE MIAMI, FL 33196 |

| (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 162 | Continued From page 14<br>assessments like that. I guess I need to get new ones for them. I will call the doctor. I didn't know the health assessment was incomplete. I will get it done right."<br><br>Class III | A 162 | | |