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
	AL11967208	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN ISLES ALF	3003 SW 156 PLACE MIAMI, FL 33185

(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 abbreviated biennial re-licensure survey was conducted at Venetian Isles ALF on . The provider had a deficiency at the time of the 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 an interview the facility failed to ensure residents whom physician has prescribed a physical have a written care plan for the use of the physical	A 033		

AHCA Form 3020-0001

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

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A 033	Continued From page 1 . . . . . (bed rails) for one out of five sampled residents (Resident #1). Findings Included: Observation on at 9:25 AM revealed full bed rails on Resident #1's bed. Review of Resident #1's record revealed a care plan for physical completed by the physician on . . . . . Further review of the record revealed no documentation of the device prescribed for use, the maximum amount of time the resident is to have the applied each day, and the 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 . On at 11:42 AM the owner acknowledged the care plan was blank. Class III	A 033		