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
	AL11968947	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SENIOR LIVING DREAM LLC	13442 SW 284TH ST HOMESTEAD, FL 33033

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated staff roster in the Background Screening Clearinghouse. Findings: A review of the facility's roster in the Background	CZ814		

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CZ814	Continued From page 1 Screening Clearinghouse Database showed four staff listed: The Administrator, Staff B, Staff C and Staff D. A review of the staff schedule showed only the Administrator and Staff B. Interviewed on at 11:55 am, the Administrator stated, after printing his roster from his Background Screening Clearinghouse queue, that his roster did not show Staff C and D as employees. He further stated that he had contacted the Background Screening unit about this problem previously, since he had received previous citations about it. He said that his consultant had updated the roster. A review of correspondence from the Background Screening unit showed that, regarding the Administrator's printed document, "It appears they provided the provisional roster and didn't change the "drop down" to show the regular roster." The correspondence further stated that this was likely why the provider could not see that the facility's roster showed staff who had not been working there for more than six months. Unclassified	CZ814		

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A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable , to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be	A 152		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 152	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment and failed to ensure that residents had the minimum furnishing in the private areas. Findings: Observations on . . . . . at 9:40 am revealed that in # , where no residents lived, the room was undergoing renovation. Observation revealed razors and other tools, cleaning supplies and construction materials left unlocked on the floor. Observation on at 10:57 am revealed Resident #1 in the hallway coming from the area of # , unsupervised by staff. Further observation revealed that Resident #1 was unable to be interviewed. A review of Resident #1's health assessment dated . . . . . showed that he was diagnosed with , . and hearing loss. Observation on at 9:45 am showed that there were no nightstands in the resident rooms. Further observation revealed stray mops, brooms, empty bottles, pesticides, old furniture, metal slats, and multiple bottles of bleach scattered throughout the . . . . yard and throughout the house in areas where residents had free access. Observation at approximately 1:00 pm showed Resident #3 seated in the yard in the midst of the debris. Interviewed on . . . . . at 11:35 am, the Administrator stated that the nightstands for the residents were in the closet of Resident #4, in # . He further stated that this resident	A 152		

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A 152	Continued From page 2 didn't use his closet because he was bed bound and under hospice care. Observation revealed that the resident's closet was filled with items which the Administrator described as partially belonging to Resident #4 and partially to the facility. Class III	A 152		
A 162 SS=E	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. , 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 , 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, , 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,	A 162		

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A 162	Continued From page 3 F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A 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 recorded semi-annually. (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:	A 162		

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A 162	Continued From page 4 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, 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	A 162		

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A 162	Continued From page 5 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, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate and up to date resident records for two out of four sample residents (Resident #1 and Resident #4). Finding include: A. A review of Resident #1's Demographic Information on . . . . . , it showed that the resident was admitted to the facility on . . . . . . A review of Resident #1's t Contract dated , it showed that the contract was signed by the Guardianship Program. A review of Resident #1's Record on . . . . . , it showed that there was no Guardianship documentation in the resident record. In an interview on . . . . . at 12:49 PM, the Administrator acknowledged that the guardianship form was not on in the resident record. B.	A 162		

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A 162	Continued From page 6 A review of Resident #4's Demographic Information on , it showed that the resident was admitted to the facility on . A review of Resident #4's Health Assessment dated , it showed that the following sections of the assessment were left blank: physical or sensory limitations, or behavioral status, special precautions, and special diet instructions. In an interview on at 12:16 PM, the Administrator acknowledged that the health assessment was incomplete. Class III	A 162		
A 000	Initial Comments A biennial re-licensure survey was conducted at A Senior Living Dream LLC on . Deficiencies were identified at the time of the survey.	A 000		
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as	A 004		

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A 004	Continued From page 7	A 004		

documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C.
(3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C.
(4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter.
(5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C.
(6) RESIDENTS RECEIVING STATE-FUNDED

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A 004	Continued From page 8 SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of a satisfactory annual health inspection of its facility. Findings included: A review of the facility records showed that the Department of Health Group Care Inspection Report was last conducted on . In an interview on at 11:40 AM the Administrator stated that they should have been there, and that the Health Department was late on their inspection. Class III	A 004		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)	A 032		

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A 032	Continued From page 9 (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family,	A 032		

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A 032	Continued From page 10 guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow its elopement policies and procedures. Resident #3 was absent from the facility for several hours without staff knowing his whereabouts. When he returned, no reassessment or elopement precautions were put in place. Findings: A review of an incident report showed that resident #3 left the facility on [redacted] without staff knowing his whereabouts. The report showed that the resident returned several hours later, stating that he went out for cigarettes. A review of Resident #3's health assessment dated [redacted] showed that he was diagnosed with [redacted], and [redacted]. The resident was identified as an elopement risk. A review of the facility's [redacted] and Elopement Policy and Procedures revealed that all residents at risk for elopement or with a history of elopement would have "identification on their persons that includes their name, the facility's name, address and telephone number."Further review of the facility's elopement policies and procedures regarding elopement found no	A 032		

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A 032	Continued From page 11 documentation of who was responsible for notifying the family, guardian, heath care surrogate or case manager if a resident eloped. There was no documentation about the continued care of other residents in the facility. Interviewed on . . . . . at approximately 12:30 pm, Resident #3 stated that he did not have identification on his person. Observation on at approximately 12:40 pm showed Resident #3's identification hanging on a wall in the hallway. Interviewed on 12:35 PM, the Administrator stated that Resident #3 was sitting on the patio and left via the side door on the day of the elopment. He stated that the resident was gone for two hours at a nearby plaza, then returned. However, a review of the police report revealed that the resident was away from the facility for over 10 hours. The Administrator stated that he did not assist Resident #3 in getting a new assessment from his health care provider but he had mentioned the elopement to them and they were coming by more often. The Administrator further stated that Resident #3 did not have identification on his person, however the identification was hanging on a nearby wall, and that if the resident wanted to go outside, they put the identification badge on him. A review of Resident #3's record found no documentation of changes in his care after the elopement. Class II	A 032		
A 033 SS=D	59A-36.007(8) PHYSICAL	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968947	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SENIOR LIVING DREAM LLC	13442 SW 284TH ST HOMESTEAD, FL 33033

(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 033	Continued From page 12 (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 record review and interview, the facility failed to have a written physical care plan for one out of four sample residents (Resident #4). Finding include: A review of Resident #'4's "Resident Consent to the use of Physical . . . . . " it showed that the resident signed the consent on . The resident consented to the use of Full Bed Rails.	A 033		

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
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A 033	Continued From page 13 A review of Resident #4's Hospice Physician Orders dated showed that the physician ordered full side rails. A review of Resident #4's Record showed that there was no documentation of a physical care plan. In an interview on at 12:16 PM, the Administrator stated that the physical care plan should be there. Class III	A 033		