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 |
|---|---|---|---|
| | AL11968340 | A. BUILDING: _____ B. WING _____ | 09/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NURSING CARE BY ANGELS, LLC | 8085 BABCOCK ST SE PALM BAY, FL 32909 |

| (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 generator monitoring survey was conducted on [redacted] at Nursing Care by Angels. Deficiencies were identified at the time of visit. | A 000 | | |
| A 182 SS=D | 59A-36.019(3) FAC Emergency Mgmt - Plan Implementation<br><br>(3) PLAN IMPLEMENTATION.<br>(a) All staff must be trained in their duties and are responsible for implementing the emergency management plan.<br>(b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on Observation, record review, and interview the facility failed to have staff available to effectively and immediately operate and maintain the alternate power source.<br><br>Findings:<br><br>On [redacted] at 9am a tour for generator monitoring was conducted with the owner. The owner was observed removing the tarp that covered the 2 generators. The generators were affixed to a concrete slab next to the house. After removing the tarp and walking around the generators, she said she was unable to start the generators. She said she did not know how. Only the administrator could do that. She said the administer was not available at the time of the survey because he was at work. The owner attempted to call someone who could start the generators but was unsuccessful. | A 182 | | |

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 |
|---|---|---|---|
| | AL11968340 | A. BUILDING: _____ B. WING _____ | 09/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NURSING CARE BY ANGELS, LLC | 8085 BABCOCK ST SE PALM BAY, FL 32909 |

| (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 182 | Continued From page 1<br>Class III | A 182 | | |