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
	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VIEW ALF CORP	14220 KENDALE LAKES BLVD MIAMI, FL 33183

(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
CZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ˬ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ˬ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ˬ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	CZ815		

AHCA Form 3020-0001

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

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CZ815	Continued From page 1 qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently	CZ815		

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CZ815	Continued From page 2 obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or . . . . . with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible	CZ815		

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CZ815	Continued From page 3 to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria	CZ815		

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CZ815	Continued From page 4 relating to retaining [redacted] pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an	CZ815		

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CZ815	Continued From page 5 exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter,	CZ815		

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CZ815	Continued From page 6 terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a level II background screening for one of four sampled staff, (Staff C), who was providing daily assistance to all residents. Findings included: Review of the facility's roster showed that Staff C was not listed on the roster. Review of Staff C's training certificates showed all certificates were done in , and , . On , at 11:46 AM, the Administrator stated, "I did all her training because I am preparing her to work here when she gets her papers." On , at 5:04 PM, previous Staff D, who was hired from to , stated during a phone interview, "I used to work with the owner, he was always there, also [Staff C]. On , at 5:55 PM, current Resident 5's family member stated, "[Staff C's nickname] is always there, yeah [Staff C]."	CZ815		

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CZ815	Continued From page 7 Unclassified	CZ815		

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A 000	Initial Comments A Complaint Investigation (Compliant number 2022014076) was conducted at Lake View ALF, Corp. on to . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of significant changes in one of five sampled residents' records, (Resident 1). Findings included: Review of Resident 1's record showed an admission on [redacted] and a discharge date on [redacted]. The record had a health assessment dated [redacted] with diagnoses of [redacted] of native [redacted]	A 025		

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A 025	Continued From page 2 of right , of , major D deficiency, milk , prostatic hyperpiesia, , right to and COVID-19. The resident ambulated with rolling walker, and had a left , with poor vision to right , and hard of hearing. The resident was alert and partially aware to place. He needed supervision on all activities of daily living, except assistance on bathing, and . A review of progress notes dated showed, "Resident continues at stable condition, no problems at this time." Notes for "Resident remains at the same, no change at the moment." Notes for "Resident doing good, no problem at this time." Notes for "Resident remains at the same condition during this month, declining." Notes for "Resident continues stable condition, no change at the moment and he continues hospice care." On at 6:08 PM, Resident 1's family member stated, "He was in the facility receiving hospice care. We decided to transfer him because he was going to be closer to us." Further record review revealed that Resident 1's record did not have any documentation on when and why the resident was discharge, and no documentation on circumstances that brought the local authorities to the facility to investigate a very serious accusations involving the resident. Class III	A 025		

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A 029	Continued From page 3	A 029		
A 029 SS=D	429.26(4) FS Resident Care - Nursing Services 429.26 (4) Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide records of third party services for two of five sampled residents, (Residents 1, and 5). Findings included: On [redacted] at approximately 9:30 AM, observed Resident 5 on his bed; the resident was under hospice care, bedridden with a full bed rail. On [redacted] at 5:55 PM, Resident 5's family member stated, "He is receiving hospice care and they call me to let me know the status." On [redacted] at 6:08 PM, during a phone interview with Resident 1's family member, she stated, "He was in the facility receiving	A 029		

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A 029	Continued From page 4 hospice care. We decided to transfer him because he was going to be closer to us." On at 2:22 PM, during a phone exit conference with the administrator, he stated, "The record for [Resident 1] the nurse took it when he was transferred, and I have to ask the nurse where [Resident 5]'s record is, he's been receiving hospice care since ." Class III	A 029		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida,	A 030		

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A 030	Continued From page 5	A 030		

1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d),

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(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 030	Continued From page 6 F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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
	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

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A 030	Continued From page 7 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency	A 030		

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	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

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A 030	Continued From page 8 relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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A 030	Continued From page 9 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to prevent to one of five sampled residents, (Resident 1). Resident 1 suffered from Staff D, captured on the video of the	A 030		

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A 030	Continued From page 10	A 030		

facility's surveillance system, from a staff person for an unknown period of time. When informed of the [redacted], the administrator failed to report it to law enforcement and failed to protect the resident.

Findings included:

Review of two videos, one provided by the administrator and another retrieved from the facility's camera system, showed Resident 1 sitting on a recliner in the common living area of the facility. Two other residents were present. Staff D was observed next to the resident with one of his arms around Resident 1's [redacted] and the other one holding Resident 1's right arm. Further review showed Resident #1 pushing the staff away, while the staff continued to kiss the resident on the [redacted]. Review of the videos revealed that Staff D pushed Resident #1 down forcibly into a chair in the dining room when the resident attempted to stand up. Review of the videos revealed that Staff D held Resident #1's [redacted] down forcibly for several minutes. The staff was observed reviewing his cellular phone with his left [redacted] while he continued to hold Resident #1's [redacted] down with his right [redacted]. Review of the videos revealed that Staff D choked Resident #1 by wrapping both [redacted] around the resident's [redacted]. Review of the videos revealed that Staff D used his [redacted] to cover the resident's [redacted] and push the resident's [redacted] forcefully.

Further review of the videos revealed that Resident #1 appeared to be trying to stop Staff D from kissing him. The resident pushed the staff and was hitting the staff, but the staff held the resident's [redacted] so he could not move, and hit the resident. Later on the same video, Staff D assisted the resident to get up and use his walker

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 11	A 030		

at the same time hitting the resident's [redacted] while the resident was walking. On the second video, the resident and Staff D are observed walking out of the resident's room; when walking, the staff stopped and kissed the resident on what appears to be his [redacted].

Review of previous Resident 1's record showed an admission on [redacted], and a discharge date [redacted]. The record had a health assessment dated [redacted] with a diagnoses of [redacted] of native [redacted] of right [redacted] of [redacted], major [redacted] D deficiency, milk [redacted] prostatic hyperplesia, [redacted], right [redacted] to [redacted] and COVID-19. The resident ambulated with rolling walker, and had a left [redacted] with poor vision to right [redacted], and hard of hearing. The resident was alert and partially aware to place. He needed supervision on all activities of daily living, except assistance on bathing, and [redacted].

On [redacted] at 9:55 AM, Resident 2 stated regarding Staff D's behavior, "He was more focused on both men because they needed more help than the rest of us."

On [redacted] at 10:14 AM, the Administrator stated, "[Staff B] reviewed the videos and that's when she saw what what's happening. We were having issues with him because he was treating [Resident 1] in a strange way; he would change his clothes multiple times a day, would play with him all the time, put his

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A 030	Continued From page 12	A 030		

personal clothes, and sunglasses. He treated everyone the same, but for some reason [Resident 1] was his favorite. He would take photos with him, put his own clothes to him, change his shoes. I spoke to him and told him that it was not a way to treat the residents, but he continued. They used to sing, and smoke together."

A review of facility records found no documentation of the Administrator's conversation with Staff D. There was no documentation of disciplinary action or retraining regarding Staff D's behavior toward

On [redacted] at 10:43 AM, the Administrator stated, "[Resident 1] and hit himself with the walker, and got a black ; that's what [Staff D] told me, that he thought he ; he picked him up, and I called the doctor. He was declining, he started hospice care."

Review of Resident 1's primary physician's notes showed:

"[redacted] He is seen for difficult to control . Stays awake most of the night. [redacted] left [redacted] on left , left lower .
Enrolled in comfort care
[redacted] Enrolled in hospice care due to functional decline."

Review of Staff D's record showed a hire date [redacted], and end date on [redacted]. The record had all required training dated from [redacted] to [redacted], including Resident Rights, [redacted], Neglect on .

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A 030	Continued From page 13 On . at 5:04 PM, during a phone interview, Staff D stated, "I worked there only few months, I was recommended. One day, I woke up and the police was there and took me in custody. I arrived from [my country] in and went directly there because I did not have a place to stay. The police happened in or . I called the owner. I was the same way with all residents. [Resident 1]'s family would never go to visit him; he was alone; I used to kiss him on his , even in front of everyone. I took photos of him with my sunglasses; someone gave me two pairs, so I gave him one of them. I used to work with the owner, he was always there, also [Staff C]. I used to love it there because we all worked good together. [Resident 1] used to a lot, he was very restless, , used to hit his when falling. The detective told me that he was going to check the videos and depending on what he saw he might let me go, and they did. I used to give [Resident 1] perfumes, clothes, used to cut his hair; he was like my grandfather, and he used to say that I was his grandson." On . at 6:08 PM, during a phone interview, Resident 1's family member stated, "He wanted us to transfer him; he asked me if he could come to live with us." Interviewed on . at 2:58 pm, Staff B stated, " I saw the cameras; I called my husband (Administrator). I told him what I saw, I called the police and [ ], the investigator. My husband did not believe me. I made the report, he told the police I was , , that I did not have mental capacity, then I showed the police. [Staff C] knows about this. I know [Resident #1] for a long time, it was always an excuse from the staff that he ; he would say, he . I believe the staff	A 030		

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A 030	Continued From page 14 started in , . I started complaining about a couple of months. I made the call on , , the police came." Class I	A 030		
A 162 SS=D	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, F.A.C., if applicable.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

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A 162	Continued From page 15 (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (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. (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 [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ([illegible]), CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

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A 162	Continued From page 16 =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 resident from the facility unless it is required by	A 162		

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 162	Continued From page 17 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 observation, record review and interview, the facility failed to provide updated health assessments for two of five sampled residents, (Residents 1, and 5). Findings included: Review of previous Resident 1's record showed an admission on [redacted], and a discharge date [redacted]. The record had a health assessment dated [redacted] with a diagnoses of [redacted] of native [redacted] of right [redacted] of [redacted] major [redacted] D deficiency, milk [redacted] prostatic hyperpiesia, [redacted], right [redacted] to [redacted] and COVID-19. The resident ambulated with rolling walker, and had a left [redacted] with poor vision to right [redacted], and hard of hearing. The resident was alert and partially aware to place. He needed supervision on all activities of daily living, except assistance on bathing, and [redacted].	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

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A 162	Continued From page 18 On [redacted] at 6:08 PM, Resident 1's family member stated, "He was in the facility receiving hospice care." The record did not have a new health assessment to reflect the resident under hospice care. On [redacted] at approximately 9:30 AM, observed Resident 5 on his bed; the resident was under hospice care, bedridden with a full bed rail. Review of Resident 5's record showed an admission on [redacted] with a health assessment dated [redacted]. The resident had [redacted] to [redacted] with a diagnoses of [redacted] of left lower extremity, [redacted] prostatic hyperplesia, [redacted], and [redacted]. The resident was using [redacted]. The resident had diminished visual acuity, poor coordination, and balance; also [redacted]. The resident used walker for mobility, and was very [redacted] with [redacted] precautions. The resident needed supervision on all activities of daily living, except for assistance when bathing, grooming and toileting. The record had a prescription for hospice evaluation dated [redacted]. There was no other updated health assessment on record to show the resident was receiving hospice care. On [redacted] at 12:15 PM, the Administrator stated, "The doctor did not update the health assessments." Class III	A 162		

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 165	Continued From page 19	A 165		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967653	A. BUILDING: _____ B. WING _____	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VIEW ALF CORP	14220 KENDALE LAKES BLVD MIAMI, FL 33183

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A 165	Continued From page 20 incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a	A 165		

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A 165	Continued From page 21 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report to the agency an adverse report for an event that was reported to law enforcement for further investigation that implicated one of its staff and one of five sampled residents, (Resident 1). Resident 1 suffered . . . . . , captured on camera by the facility's video surveillance system, from staff D for an unknown period of time. Findings included: Review of two videos, one provided by the administrator and another one by one of the investigators, showed Resident 1 sitting on a recliner at the Living area of the facility; Staff D next to the resident with one of his arms around Resident 1's . and the other one holding Resident 1's right arm; the resident was trying to stop the staff for apparently kissing him; the resident pushed the staff and was hitting the staff, but the staff hold the resident's so he could not move, and hit the resident . . . . Later on the same video, Staff D assisted the resident to get up and provide his walker at the same time hitting the resident's while this one is walking. On	A 165		

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A 165	Continued From page 22 the second video, the resident and Staff D are observed walking out of the resident's room; when walking, the staff stopped and kissed the resident on what appears to be his . These videos were obtained from the facility's camera system. On , at 10:14 AM, the Administrator stated, "[Staff B] reviewed the videos and that's when she saw what what's happening. We were having issues with him because he was treating [Resident 1] in a strange way; he would change his clothes multiple times a day, would play with him all the time, put his personal clothes, and sunglasses. He treated everyone the same, but for some reason [Resident 1] was his favorite. He would take photos with him, put his own clothes to him, change his shoes. I spoke to him and told him that it was not a way to treat the residents, but he continued. They used to sing, and smoke together." On , at 10:43 AM, the Administrator stated, "[Resident 1] and hit himself with the walker, and got a black ; that's what [Staff D] told me, that he thought he ; he picked him up, and I called the doctor. He was declining, he started hospice care." On at 5:04 PM, during a phone interview, Staff D stated, "I worked there only few months, I was recommended. One day, I woke up and the police was there and took me in custody. I arrived from [my country] in and went directly there because I did not have a place to stay. The police happened in or . I called the owner. I was the same way with all residents. [Resident 1]'s family would never go to visit him; he was alone; I used to kiss him on his	A 165		

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A 165	Continued From page 23 . . . , even in front of everyone. I took photos of him with my sunglasses; someone gave me two pairs, so I gave him one of them. I used to work with the owner, he was always there, also [Staff C]. I used to love it there because we all worked good together. [Resident 1] used to a lot, he was very restless, . . . , used to hit his . . . when falling. The detective told me that he was going to check the videos and depending on what he saw he might let me go, and they did. I used to give [Resident 1] perfumes, clothes, used to cut his hair; he was like my grandfather, and he used to say that I was his grandson." Review of the facility's adverse incidents showed that none had been filed. Class III	A 165		