

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967891</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BIRD'S RESIDENCE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>840 SW 50TH AVENUE<br/>MARGATE, FL 33068</b>                                 |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                            | Initial Comments<br><br>An unannounced Relicensure and Generator Monitoring survey was conducted on _____ at Bird's , Residence, LLC. The facility had deficiencies identified related to the Relicensure at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A 000                                                                          |                                                                                                                          |  |                                                        |
| CZ814                                                            | 435.12(2)(b-d), FS Background Screening Clearinghouse<br><br>435.12 Care Provider Background Screening Clearinghouse.-<br>(2)(b) Until such time as the _____ 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.<br>(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.<br>(d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ 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; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. | CZ814                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BIRD'S RESIDENCE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>840 SW 50TH AVENUE<br/>MARGATE, FL 33068</b>                                 |                          |                                                        |
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| CZ814                                                            | <p>Continued From page 1</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, it was determined the facility failed to provide proof that it registered Staff C, a direct care employee and maintained their employee status within the Background Screening (BGS) Clearinghouse, for 1 out of 4 employee records sampled employee Staff C.</p> <p>The findings include:</p> <p>Review of the personnel file for Staff C who is a direct care employee, revealed her date of hire as , and she works a direct care staff.</p> <p>This Staff member was observed providing direct care to residents, feeding, turning, and changing their diapers. Further review of her file failed to show that she had been registered within the Clearinghouse. Additional review of the facilities Clearinghouse Roster also confirmed that she was not registered.</p> <p>During an interview with the Administrator on . . . . at 12:27PM, she was asked for the personnel file for Staff C which she provided, then stated "all staff documentation is kept in one book."</p> <p>During an interview with the Administrator on . . . . at 1:20PM request was made to provide documentation indicating that Staff C had been registered with the Clearinghouse.</p> <p>In an interview conducted with the Administrator on . . . . at 1:55PM, second request for the documentation was made. On . . . . at 4:43pm, the Administrator was advised BGS had not been provided for staff C.</p> <p>Unclassified</p> | CZ814                                                                          |                                                                                                                          |                          |                                                        |

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| CZ816                                                            | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CZ816                                                                          |                                                                                                                          |                          |                                                        |
| CZ816                                                            | <p>408.809(2) 435.05(2) 59A-35.090(2d-3b)<br/>Background Screening-Compliance Attestation</p> <p>408.809 Background screening; prohibited offenses.-</p> <p>(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance</p> | CZ816                                                                          |                                                                                                                          |                          |                                                        |

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| CZ816                                                            | <p>Continued From page 3</p> <p>with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:</p> <p>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;</p> <p>(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and</p> <p>(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.</p> <p>435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:</p> <p>(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.</p> <p>59A-35.090 Background Screening.</p> <p>(2) Processing Screening Requests, Required Documents and Fees.</p> <p>(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09106">http://www.flrules.org/Gateway/reference.asp?No=Ref-09106</a>, and available from the Agency for</p> | CZ816                                                                                    |                                                                                                                          |  |                                                        |

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| CZ816                                                            | <p>Continued From page 4</p> <p>Health Care Administration at:<br/><a href="http://ahca.myflorida.com/MCHQ/Central_Service/s/Background_Screening/Regulations_Forms.shtm">http://ahca.myflorida.com/MCHQ/Central_Service/s/Background_Screening/Regulations_Forms.shtm</a>. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any disqualifying offense.</p> <p>(e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position.</p> <p>(3) Results of Screening and Notification.</p> <p>(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: <a href="http://apps.ahca.myflorida.com/SingleSignOnPortal">apps.ahca.myflorida.com/SingleSignOnPortal</a>.</p> <p>(b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the _____ report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 4 sampled direct care staff (Staff B) had a signed Attestation of</p> | CZ816                                                                          |                                                                                                                          |  |                                                        |

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| CZ816                                                            | Continued From page 5<br><br>Compliance with Background Screening Requirements (AHCA Form 3100-0008, ) at the time of hire.<br><br>The findings included:<br><br>Review of the employee record for direct care staff (Staff B), a Direct Caregiver hired on , revealed no signed Attestation of Compliance with Background Screening Requirements (AHCA Form 3100-0008, ) had been completed at the time of hire.<br><br>On at 1:20 PM, the Administrator was notified of the missing documentation for Staff B. She stated she would look through her records for the missing form and provide it, if found.<br><br>As of at 4:45 PM, the Administrator never followed up with Surveyor regarding no signed Attestation of Compliance with Background Screening Requirements for Staff B had been provided.<br><br>Unclassified | CZ816                                                                          |                                                                                                                          |  |                                                        |
| CZ830                                                            | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:                                                                                                                                                                                                                                                                                                    | CZ830                                                                          |                                                                                                                          |  |                                                        |

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| CZ830                                                            | <p>Continued From page 6</p> <p>(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.</p> <p>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.</p> <p>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.</p> <p>(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.</p> <p>(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.</p> <p>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:</p> <ol style="list-style-type: none"> <li>1. Suffered damage to its operation during the state of emergency.</li> <li>2. Is currently licensed.</li> <li>3. Does not have a provisional license.</li> <li>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.</li> </ol> <p>(b) An inactive license may be issued for a period</p> | CZ830                                                                                    |                                                                                                                          |  |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967891</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BIRD'S RESIDENCE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>840 SW 50TH AVENUE<br/>MARGATE, FL 33068</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| CZ830                                                            | <p>Continued From page 7</p> <p>not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.</p> <p>(4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a current CEMP on file approved by the county emergency management agency.</p> <p>Findings included:</p> | CZ830                                                                                    |                                                                                                                          |  |                                                        |



Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967891</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BIRD'S RESIDENCE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>840 SW 50TH AVENUE<br/>MARGATE, FL 33068</b> |                                                                                                                          |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ830                                                            | <p>Continued From page 8</p> <p>Review of the facility's last CEMP was approved on _____ and would expire on _____. The facility has not submitted their CEMP to the county for review on an annual basis and no evidence of a resubmission after the expiration.</p> <p>On _____ at 4:43 PM, the Administrator stated she is yet to submit the CEMP to the Broward County Emergency Management Plan Agency for approval. She acknowledged the finding. No additional documentation provided by the Administrator.</p> <p>Unclassified</p> | CZ830                                                                                    |                                                                                                                          |                          |                                                        |