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
	AL11968099	A. BUILDING: _____ B. WING _____	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTLER BAY VILLAGE ALF	10425 SW 212 STREET CUTLER BAY, FL 33189

(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 A re-licensure survey was conducted at Cutler Bay Village ALF on [redacted] & [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 075 SS=D	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw [redacted] or the use of an automated external defibrillator if presented with an order not to [redacted] executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing [redacted] or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to [redacted] executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing [redacted] or use of an automated external defibrillator as otherwise permitted by law.	A 075		

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
	AL11968099	A. BUILDING: _____ B. WING _____	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTLER BAY VILLAGE ALF	10425 SW 212 STREET CUTLER BAY, FL 33189

(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 075	Continued From page 1 (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observation and interviews the facility failed to always have a functioning automated external defibrillator ( ) on the premises Findings included: A review of the facility's posted Assisted Living Facility license showed that it is licensed for 47 beds. On at 2:25 PM, observed the Automated External Defibrillator ( ) was located in the medication cabinet. Futher observation showed the Administrator tried to turn on the facaility's however was unsucessful. According to the Red Cross, an , or automated external defibrillator, is used to help those experiencing sudden . It's a sophisticated, yet easy-to-use, medical device that can analyze the 's rhythm and, if necessary, deliver an electrical , or , to help the re-establish an effective rhythm. A review of resident record found that 18 residents did not have a on file, and preferred to be if they became unresponsive. On at 3:05 PM, the Administrator acknowledged that Automated External Defibrillator ( ) was not working.	A 075		

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
	AL11968099	A. BUILDING: _____ B. WING _____	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTLER BAY VILLAGE ALF	10425 SW 212 STREET CUTLER BAY, FL 33189

(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 075	Continued From page 2 Class II	A 075		
A 083 SS=E	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff members possess a valid , , ( ) certificate that requires the staff to demonstrate, in person, that he or she is able to perform for three of three sampled staff (Staff D, Staff E and Staff F. Sampled staff current training was completed online. Findings Included:	A 083		

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
	AL11968099	A. BUILDING: _____ B. WING _____	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTLER BAY VILLAGE ALF	10425 SW 212 STREET CUTLER BAY, FL 33189

(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 083	Continued From page 3 A review of the employee records showed three staff members (Staff D, Staff E, and Staff F) did not have a current ( ) and hold a currently valid card on file. All staff had completed an online training. Staff D was hired on , Staff E was hired on , and Staff F was hired on however all staff had completed online training. None of the staff had certified training. In an interview with the Administrator on at 3:05 pm, he stated all of the staff completed training online because, during the pandemic, no in-person training was available. He further stated," This was a refresher course". Class III	A 083		