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
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 Complaint survey (Complaint #2023012917) was conducted at Bosch ALF, Inc on through . Deficiencies were identified at the time of the survey.	A 000		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to facilitate resident access to health care services for one out of seven sampled residents (Resident #1). Resident #1 sustained a and no documentation the health care provider was notified, and no health care services were arranged. Facility staff did not notify the health care provider. Findings included: Review of Resident 1's record showed a health assessment dated . The resident had medical history and diagnoses as , ,	A 027		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 027	Continued From page 1 , old ( ), {OA}/ , ( ), . The resident was frail elderly, unsteady gait, walker dependent. The resident needed assistance with ambulation, bathing, , self-care , toileting and transferring with activities of daily living, The resident had mild , (MCI) and required special precautions for . In an interview in at 11:35 AM the Administrator stated, on / 2023, Resident #1 hit her arm in the shower, she never . I was assisting her with the bath, and she refused to go to the doctor. I checked her and she had mobility and no , . I called Leon and spoke with the assistant of Doctor (I did not ask her name). She told me that if the resident did not have , it was okay if she did not want to go to the doctor. The following days, , , , she was okay, we never gave her any medications because she had no , . We only put her ice packs daily for about an hour once or twice a day when she was lying down in bed. Her arm from the to the had a , like a normal color when someone hits. Then down the was purple, I did not call the doctor again because she had no , . On Saturday, her family visited her, and they tried to get her out of bed and moved her arm around. The next day, Sunday in the afternoon they came , and I believe because of the manipulation they did to her arm, it turned black. When I saw her arm was purple/black and , I told the granddaughter that I was calling the ambulance. I called a non-emergency transportation company. It took them about 20 minutes to arrive and when they came, they did not take her because they saw she was too down, so they called the rescue.	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 027	Continued From page 2 She did not seem in distress. The reason I was sending her to [Hospital] was because she had a contract there and all the doctors from [clinic] worked there. The rescue came like 5 or 10 minutes later, they did not say anything they just asked me what had happened. They transported her to the [hospital]. A review of the hospital record documented that on Resident #1 was admitted to the hospital where left arm was found broken and the skin was black in color (photographic evidence obtained). Further review of the hospital record showed: "Patient arrived from nursing facility critically ill, hypertensive, tachycardic in A fibrilation with Rapid response (RVR) and distress with . Patient appeared with dry and poor skin . Bedside consistent with with (IVC) collapse. Treated with broad-spectrum for . Left arm grossly edematous with diffuse (with discoloration of the skin caused by underneath). confirmed in imaging. International Normalized Ratio (INR) elevated. Patient with high probability of imminent or life-threatening deterioration in condition due to failure and concern for . According to the National Institutes of Health, " , also known as or AF, is one of the most common types of are problems with the rate or rhythm of your heartbeat. They can cause your to beat too slowly, too fast, or in an irregular way."	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 027	Continued From page 3 " . . . is a state in which . . . is not available in sufficient amounts at the tissue level to maintain adequate . . . . . ; this can result from inadequate . . . delivery to the tissues either due to low . . . supply or low . . . content in the (hypoxemia). Further review of Resident #1 medical record showed no documentation the health care provider was notified or that the health care services was arranged for residents' . . A review of the health care provider's records found that the last contact with the resident had been on . . . . . , five days before the resident was injured and ten days before she was hospitalized. Class II	A 027		
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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 4 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, 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 5 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), 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 . . . . . 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	AL11965853		11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 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, 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,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 7 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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 8 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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 9 resident. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to honor one out of seven (Resident #1) sampled residents' rights to ensure she received adequate and appropriate health care, treated with consideration, respect and was free from [illegible] and neglect. Resident #1 did not receive care for the injuries (broken left [illegible]) she sustained in the facility after a [illegible] aside from an ice pack applied by unlicensed staff, for five days after the injury was identified. Findings included: A review of the hospital record documented that on [illegible] Resident #1 was admitted to the hospital where left arm was found broken and the skin was black in color (photographic evidence obtained). Further review of the hospital record showed: "Patient arrived from nursing facility critically ill, hypertensive, tachycardic in A fibrillation with Rapid [illegible] response (RVR) and [illegible], distress with [illegible]. Patient appeared [illegible] with dry [illegible] and poor skin [illegible]. Bedside [illegible] consistent with [illegible] with [illegible] (IVC) collapse. Treated with broad-spectrum for [illegible] Left arm grossly edematous with diffuse [illegible] (with discoloration of the skin caused by [illegible] underneath). [illegible] confirmed in imaging. International Normalized Ratio (INR) elevated. Patient with high probability of imminent or	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 10 life-threatening deterioration in condition due to , failure and concern for . According to the National Institutes of Health, " , also known as or AF, is one of the most common types of . are problems with the rate or rhythm of your heartbeat. They can cause your to beat too slowly, too fast, or in an irregular way." is a state in which is not available in sufficient amounts at the tissue level to maintain adequate ; this can result from inadequate delivery to the tissues either due to low supply or low content in the (hypoxemia). In an interview in / 23 at 11:35 AM the Administrator (phone interview) regarding the resident's blackened arm, she stated. "On , she hit her arm in the shower, she never . I was assisting her with the bath, and she refused to go to the doctor. I checked her and she had mobility and no . I called primary care office and spoke with the assistant of doctor . I did not ask her name. She told me that if the resident did not have , it was okay if she did not want to go to the doctor. The following days, , , she was okay, we never gave her any medications because she had no , . We only put her ice packs daily for about an hour once or twice a day when she was lying down in bed. Her arm from the to the had a , like a normal color when someone hits. Then down the was purple, I did not call the doctor again because she had no , . On Saturday, her family visited her, and they tried to get her out of bed and moved her arm around. The next day, Sunday in the afternoon they came , and I believe because	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 11 of the manipulation they did to her arm, it turned black. Staff C was here, and I spoke with the resident's granddaughter and let her know I was on my way. When I saw her arm was purple/black and . . . . . , I told the granddaughter that I was calling the ambulance. She told me to leave her until the next day, when the nurse for hospice was coming for the evaluation. I said no to her and called the ambulance. I called [non-emergency transportation]. I always call. It took them about 20 minutes to arrive and when they came, they did not take her because they saw she was too down, so they called the rescue. She did not seem in distress, I talked to her, and she ate an applesauce, she was normal. Another thing, her grandson came and did a big scene because she did not want her to be transported [Hospital], so he went inside the ambulance to speak with them, and they took her down from the ambulance and called 911. The reason I was sending her to [Hospital] was because she had a contract there and all the doctors from [clinic] worked there. The rescue came like 5 or 10 minutes later, they did not say anything they just asked me what had happened. They transported her to the [Hospital]. " In an interview on at 12:12 PM called Staff B (phone interview): stated, "I have been working here for 12 years and with Resident #1 I have not had any issues. On the day she hit her arm I was working but I was not assisting her with the bath. It was Administrator and what she told me happened was that Resident #1 lost balance and hit her arm with the grabbed bar. After that Resident #1 was fine and she said that had no , . . . I assisted her with Administrator to get dressed. The Administrator called [clinic]; I do not know what they said to her. The days after, I helped Administrator, so both assisted her to get	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 12	A 030		

bathed and dressed. We put her ice packs maybe 1 or 2 times, but her arm did not swell. After the the color on her entire arm was normal like dark purple. She got that color since she started with , probably like a month earlier. She came with a from rehab where she was after a . So, she was scratching her arm with a brush. It was on Sunday, according to what [Administrator] told me that her arm changed to a darker color (that day I was not working). If a resident had a medical condition what I would do first if is urgent is to call 911, then if it is a or something minor, I communicate with the doctor.

A review of facility Progress Notes - Translated from Spanish showed:
- In the morning while being assisted with bathing, the resident lost her balance and hit her left arm with the grab bar. Immediately, she was assisted by the Administrator and the staff present confirming mobility and , . For which, the resident responded with no problem. Immediately we informed her doctors and family explaining to them what had happened, and that the resident did not want to go to the clinic for an evaluation. She said that because nothing had happened. We assisted her to get dressed in with no mobility issues and finishing this note we asked the resident to sign it as evidence that she was refusing to be evaluated nor transported anywhere including the clinic where she goes for her doctors. Note at the end had handwritten "[Resident #1 signed]."
- The resident continues stable with the arm, only it had changed from color, due to age and the she takes and arm previously damaged because of the diagnosed in the past. With the hairbrush, the resident had damaged the skin and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 13	A 030		

presenting a change in color. Her doctors and family were aware of everything. She continues with her persistent conditions, depressed, eating very small amounts and barely wanting to get out of bed. Spoke with her granddaughter, who try to cheer up the resident for which she said that she wanted to rest and did not want to go to the doctor from the Medical Center for which she agreed and said that everything was due to the process she was going through.

- The resident was visited by her family who saw the conditions in which the resident was in bed, she did not present any , only she was refusing to eat regularly, only small portions of liquids, soup, and pureed food. The family took the decision to have the resident evaluated for Hospice. She was evaluated for the service and her family signed the consents for that service.

- She was evaluated by registered nurse (RN) and all her vitals were stable. She responded when they called her but could not give her the medications. She refused to take the medications because she said that they were difficult to swallow, and she did not need them. It was signed refused to medications due to resident right.

- Her family was in the ALF (assisted living facility), they tried to cheer her up to eat something else, but she refused. They tried to get her out of bed and move her. In the afternoon/evening, the resident started complaining of , in her left arm and presenting change in color for circulation likely for the position in bed. We called the family and the ambulance, and the resident was transported to [Hospital].

Interviewed on at 12:35 PM, Resident #1's family member stated, "[Resident #1] on Tuesday . I was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 14	A 030		

working and [Administrator] called me and told me that they put [Resident #1] to bathe, and she got . She slipped in the shower and hit her left . I said to them that when I get to Florida, I will go to see her and told them to take her to the emergency room at Leon or to the hospital. Then, [Administrator] told me that it was not necessary because they put her ice packs on the . On Wednesday, at about 10:00 AM, [Administrator] called me and told me that [Resident #1] did not want to eat, she was lying down on the bed staring at the wall and shaking. She told me to go see her, I replied that I will go on Friday and asked to speak with her. [Administrator] told me that [Resident #1] was not talking, and she was like in a . [Resident #1] was never hospitalized for COVID-19, she had it without symptoms, one month before she went to the hospital for a follow-up and tested positive. Then, she had an , , , but I cannot remember which doctor. COVID was at the beginning of and the was on . It was about months earlier that she was not eating the same and 2 months before it was when she started needing more help. After the , I maintained communication with the owner. Then, I went to the facility on Saturday , [Resident #1] was on bed and breathing heavily (very agitated/accelerated), had her , closed, she was not responding, was shaking, and staring to the wall on the right side. No doctor went to see her, and her were . I looked at her left arm and pulled up the sleeve and from her to the it was black. I told the staff [Staff D] why they had not sent her to the hospital, and she told me that on [Administrator]'s order, they were just putting her ice packs. [Administrator] was not there. The next day, we went to see her again and she had ice packs. They moved her and opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 15 her to give her a medication with a spoon mixed with pudding. The staff put the spoon in her and wiggled and pushed it to her to make her swallow. I said to the staff that this was not right, and I was leaving but I was going to call the [Administrator]. I live in [County] and when I got home [Administrator] called me and told me that [Resident #1] was not well. I told her to call the ambulance and asked my brother who lives about 10 minutes from the facility to go there. [Administrator] called an ambulance to take [Resident #1] to [Hospital]. When the ambulance came, they told her that they could not take [Resident #1] to [Hospital] because she was in a very bad condition and her was too low. They told [Administrator] that they were not responsible and only worked for [Hospital], so to call 911. [Administrator] called 911 and when the rescue came and asked about what happened, [Administrator] in front of my brother told them [Resident #1] had that morning. On they took her to [Hospital B]. I went to see her at the hospital, and she was diagnosed with ( ), , and , failure." A review of the clinic record documented the last time Resident #1 was seen was on in the urgent care with complaints of . A review of the facility's policy showed the following, "If residents at the facility, the resident will be immediately assessed to determine if any bones or injuries occurred. As needed and when needed all are to be called out to emergency medical transport (EMT) for transfer of of the resident from the facility to unit providing more acute care due to the incident rather than the resident's condition before the incident. Resident will be assessed by the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 16 emergency medical transport (EMT) before going to the hospital. Contact the resident's Doctor and representative/ guardian. Document all findings, outcome of the incident, apparent cause, and corrective or proactive action(s) taken in the resident's chart and submit adverse incident reports via the AIRS system. Continue to coordinate with the Doctor all resident's needs and treatment, discharge instructions from the unit that provided acute care and making sure the health assessment reflect current resident's health and needs." A review of the employee file showed Administrator hired on . Trainings in resident rights in an assisted living facility and recognizing & reporting , neglect , dated . Staff B hired on . Trainings in resident rights in an assisted living facility and recognizing & reporting , neglect , dated . Staff C hired . Trainings in resident rights in an assisted living facility and recognizing & reporting , neglect , dated . Class I	A 030		
A 163 SS=D	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.	A 163		

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
	AL11965853	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 163	Continued From page 17 (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the resident record was not falsified for one of six sampled residents (Resident #1). Findings included: On , observed documentation of statements given by Administrator for stated she contacted Resident #1's primary care physician about the resident's on . Record review of the progress notes dated 01/011/23 showed that the facility documented, regarding Resident #1's , "Immediately we informed her doctors and family explaining to them what had happened, and that the resident did not want to go to the clinic for an evaluation." Review of medical record from primary care physician (PCP) showed the last time the office was contacted was on . In an interview on the Administrator confirmed the last time she communicated with the PCP (primary care provider) was when Resident #1 was admitted to medical center on . Class III	A 163		