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
	AL11965248	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME FOR ALL THE ANGELS CORP	9270 SW 42 TERRACE MIAMI, FL 33165

(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 investigation (Complaint #2024002934) was conducted at Home for all the Angels Corp. on . The provider had deficiencies at the time of the visit.	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 resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 observation, record review and interview the facility failed to offer appropiate supervision to one out of six residents (Resident #2). Resident under risk with no injuries. Findings as follow: On at 11:18 AM Resident #2 in facility from the recliner. Administrator and Staff B were next to him when it happened, they assisted him to sit on. The Administrator called 911 who assessed him and they determined it was not need to transfer resident to the hospital. at 11:20 AM Resident's walker was	A 025		

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A 025	Continued From page 2 observed in his room while resident was in the living room. On at 1:37 PM Staff B stated Resident #2 walked assisted by staff. He did not use the walker, but she agreed to say that he needed to use it. She stated for staff was more comfortable having him walking with staff assistance instead than with a walker. Review of Resident #2 assessment dated showed resident had a medical history of of , ectasia, affect, other secondary , , , other abnormality of gait and mobility, frequency of micturition, anterograde amnesia. He had physical limitation with ambulation and activities of daily living, he had secondary parkisonism and early onset and resident was under special precautions for . Further review of Resident #2's record showed resident was prescribed the use of walker on 05//22/2023 and he also had a prescription for the use of half bedrails. Resident physical plan of care dated signed by a Physician documented resident had a high risk level for . Observation notes review showed no previous documented. Class III	A 025		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical	A 033		

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A 033	Continued From page 3 . . . . . must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical . . . . annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical . . . . and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to have a prescription for the use of physical . . . . for one out of six residents (Resident #1). Findings as follow: On at 9:00 AM observed Resident #1 in bed with full bedrails in up position. Review of Resident #1's records showed there was not a prescription for the use of bedrails. On at 1:00 PM the Administrator	A 033		

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A 033	Continued From page 4 stated she would request the bedrail prescription for Resident #1. Class III	A 033		
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 resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form 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. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.	A 162		

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A 162	Continued From page 5 (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. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that [illegible] not be taken. (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] ( ), CF-ES 1006, [illegible], which is hereby incorporated by reference	A 162		

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A 162	Continued From page 6 and available for review at: http://www.flrules.org/Gateway/reference.asp?No=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 [illegible] 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 [illegible], 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 a log listing the names of residents participating in this arrangement. (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 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.	A 162		

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A 162	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to have an accurate health assessment for one out of six residents (Resident #1). The facility also failed to have a consent for the use of bedrails for one out of six residents (Resident #1). Findings as follow: On at 9:00 AM observed Resident #1 in bed with full bedrails in up position. On at 9:30 AM the Administrator stated Resident #1 was bedbound and she had an on her heel. Progress notes review showed on the resident had a in facility, she was taken to the hospital and underwent a surgery for , . On Resident #1 returned to facility after a rehabilitative period. On the resident was evaluated to be admitted under the care of hospice. Review of Resident #1 Assessment available dated showed Resident was diagnosed with High tension, used walker for mobility. was not under special precautions and needed supervision eating and assistance with ambulation, bathing, , self -care, toileting, and transferring. The assesment also documented resident did not have and she was not bedbound. Review of Resident #1's record showed there was not a signed consent for the use of full bedrails.	A 162		

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A 162	Continued From page 8 Class III	A 162		