

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY'S HOME

**14158 NW 88 PLACE
MIAMI LAKES, FL 33018**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{CZ815}	408.809(1)(); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, _____ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or _____ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All _____ must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	{CZ815}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{CZ815}	Continued From page 1 qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently	{CZ815}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{CZ815}	Continued From page 2 obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible	{CZ815}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{CZ815}	Continued From page 3 to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria	{CZ815}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY'S HOME

**14158 NW 88 PLACE
MIAMI LAKES, FL 33018**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{CZ815}	Continued From page 4 relating to retaining _____ pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any _____ person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any _____ person that would place the employee in a role that requires background screening unless the employee is granted an	{CZ815}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{CZ815}	Continued From page 5 exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been _____ for a disqualifying offense, the employer must remove the employee from contact with any _____ person that places the employee in a role that requires background screening until the _____ is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with _____ persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including _____, if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or _____ for a disqualifying offense listed under this chapter,	{CZ815}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{CZ815}	Continued From page 6 terminates the person against whom the report was issued or who was _____, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that a person that provides personal care services directly to a client or has access to resident living areas, had a level II background screening completed for one out of three (Staff E) sampled staff. Findings included: On _____ at 7:00 AM observed Staff E (caretaker) alone at the facility with five residents. On _____ at 11:15 AM observed Staff E alone at the facility with five residents. On _____ at 7:25 AM, Staff E stated, "I have been working here for 2 weeks." A review of the Clearinghouse database revealed that Staff E had no level II background screening completed. On _____ at 8:20 AM, the Administrator stated, "I asked [Staff E] to come to the facility and work, because another staff member had an _____ and I needed someone to cover the	{CZ815}			

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018			
(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 revisit to a re-licensure survey was conducted at Mary's Home from _____ to _____. The provider had deficiencies identified at the time of the survey.	{A 000}			
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, _____, and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by	A 031			

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: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 031	Continued From page 1 the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure to coordinate with third party services and maintain documentation about the resident's condition and response to treatment or	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 031	Continued From page 2 services ordered by the physician for one out of six sampled residents (Resident # 6). Findings included: A review of residents' records revealed that Resident # 6 had a _____ to the left _____ and a _____ of the _____. Further review of the records showed no documentation of _____ care services and treatment. On _____ at 8:59 AM, the Administrator stated that Resident # 6 had a _____ on the _____ and received _____ care daily. She stated that the resident also had a _____ on the left heel that had already healed. The Administrator stated that she did not know the name of the home health agency that provide the services/treatment to the _____. She stated she did not have documentation regarding the resident _____ care. On _____ at 9:10 AM, Resident # 6 stated a nurse comes every day to provide _____ care on his _____ and that the _____ on the left heel had already healed. Resident #6 stated he did not know the name of the home health agency. He stated that he just signs the paper before the nurse leaves. Class III	A 031			
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024																						
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018																								
(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 079	Continued From page 3 staff hours per week: <table> <tr> <td>Number of Residents, Day Care Participants, and Respite Care Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td></td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> <tr> <td>46-55</td> <td>375</td> </tr> <tr> <td>56-65</td> <td>416</td> </tr> <tr> <td>66-75</td> <td>457</td> </tr> <tr> <td>76-85</td> <td>498</td> </tr> <tr> <td>86-95</td> <td>539</td> </tr> </table> For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168		212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079		
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																									
0-5	168																									
	212																									
16-25	253																									
26-35	294																									
36-45	335																									
46-55	375																									
56-65	416																									
66-75	457																									
76-85	498																									
86-95	539																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 079	Continued From page 4 documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 079	Continued From page 5 apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 079	Continued From page 6 by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern. Findings included: On at 7:00 AM observed Staff E (caretaker) alone at the facility with five residents. On at 7:25 AM, concerning not being listed on the facility staff work schedule, Staff E stated, "I have been working here for 2 weeks." On at 11:15 AM observed Staff E (caretaker) alone with five residents.	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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)	
A 079	Continued From page 7 A review of the staffing schedule revealed that Staff E was not listed on the schedule. On _____ at 8:20 AM, the Administrator stated, "I asked [Staff E] to come to the facility and work, because another staff member had an _____ and I needed someone to cover the facility until I arrive." Class III		A 079		
(A 081) SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee 's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such		(A 081)		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 081}	Continued From page 8 training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:	{A 081}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 081}	Continued From page 9 (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs.	{A 081}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 081}	Continued From page 10 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure staff completed the required trainings, within 30 days of employment for one out of three sampled staff (Staff B). Findings Included: A review of Staff B (live-in caretaker) employee record showed a hired date on Further review of the record showed no documentation Staff B completed the trainings for elopement, resident rights and recognizing and reporting resident, neglect, and and reporting adverse incidents and	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY'S HOME

**14158 NW 88 PLACE
MIAMI LAKES, FL 33018**

(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 081}	Continued From page 11 facility emergency procedures including chain-of-command ,staff roles relating to emergency evacuation and safe food handling on file. On at 8:55 AM, concerning Staff B trainings, the Administrator stated, "I told her to complete the trainings." Uncorrected Class III	{A 081}		
A 083 SS=D	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:	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY'S HOME

**14158 NW 88 PLACE
MIAMI LAKES, FL 33018**

(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 12 Based on observation, record review and interview, the facility failed to ensure 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. Findings included: On at 7:00 AM observed Staff E (caretaker) alone at the facility with five residents. On at 11:15 AM observed Staff E alone in the facility with five residents. On at 7:25 AM, Staff E stated, "I have been working here for 2 weeks." A review of staff personnel records revealed that Staff E had no . . . /First Aid certification on file. On at 8:20 AM, the Administrator stated, "I asked [Staff E] to come to the facility and work, because another staff member had an . . . and I needed someone to cover the facility until I arrive." Class III	A 083		
{A 090} SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one	{A 090}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018			
(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 090}	Continued From page 13 hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff receive at least one hour of training in the facility's policies and procedures regarding for one out of three (Staff B) sampled staff. Findings included: A review of Staff B records (live- in caretaker) showed a hired date on . Further review of the record showed no documentation that Staff B had completed a one hour training in the facility's policies and procedures regarding on file. On at 9:02 AM, concerning staff completion of the training, the Administrator stated that Staff B completed the training. Uncorrected Class III A 161 SS=D 429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275	{A 090}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 161	Continued From page 14 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 161	Continued From page 15 personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain personnel records for each staff member which contain, at a minimum, a copy of the employment application, documentation verifying freedom from signs or symptoms of communicable and documentation of compliance with all training requirements for one out of five sampled staff (Staff E). Findings included: On at 7:00 AM observed Staff E (caretaker) alone at the facility with five residents. On at 11:15 AM observed Staff E alone with five residents. On at 7:25 AM, Staff E stated, "I have been working here for 2 weeks." A review of the facility records showed no personnel records for Staff E, no copy of the employment application, and no documentation verifying freedom from signs or symptoms of communicable and no documentation of compliance with all training requirements on file.	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY'S HOME

**14158 NW 88 PLACE
MIAMI LAKES, FL 33018**

(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 161	Continued From page 16 On _____ at 8:20 AM, the Administrator stated, "I asked [Staff E] to come to the facility and work, because another staff member had an _____ and I needed someone to cover the facility until I arrive." Class III	A 161		
(A 200) SS=E	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure _____ air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less	(A 200)		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 200}	Continued From page 17 than twenty (20) net square . . . per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone	{A 200}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 200}	Continued From page 18 pursuant to Chapter 252, F. S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more	{A 200}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018	
(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 200}	Continued From page 19 beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval.	{A 200}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 200}	Continued From page 20 (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than _____, have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that	{A 200}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 200}	Continued From page 21 require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in _____ air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of _____ and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce	{A 200}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 200}	Continued From page 22 the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility.	{A 200}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2024
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY'S HOME

**14158 NW 88 PLACE
MIAMI LAKES, FL 33018**

(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 200}	Continued From page 23 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source(generator) maintained at the assisted living facility. Findings included: A review of facility survey history revealed that the facility was found to have a non-working generator on On at 7:20 AM observed a Generac Generator GP 6500 inside a shed in the backyard. On at 8:23 AM, the Administrator was asked to start the generator and stated that she	{A 200}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2024
NAME OF PROVIDER OR SUPPLIER MARY'S HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 14158 NW 88 PLACE MIAMI LAKES, FL 33018		
(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 200}	Continued From page 24 would not start the generator. She stated, "I could not fix the generator because I could not find a person to fix it. I do not have any money to buy a new generator." A review of facility' records revealed that there was no documentation the generator had been tested or maintenance. Uncorrected Class III	{A 200}			