

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER ALF FAMILY CARE II, CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 13480 SW 89TH TERRACE MIAMI, FL 33186		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey was conducted at ALF Family Care II Corp on The provider had deficiencies at the time of survey.	A 000			
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL Residents for whom a physician has prescribed a physical 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, interview and record review the facility failed to develop a Plan of Care for the use of physical for one out of six sampled residents (Resident #2) who was observed restrained to a chair.	A 033			

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

TITLE

(X6) DATE

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A 033	Continued From page 1 Findings as follow: On at 7:00 AM and, during the time the survey last, observed Resident #2 sitting in a chair, restrained to it by a tray attached to the chair which the resident was unable to remove without staff assistance. On at 7:05 AM Staff B stated Resident #2 was unable to remove the tray by herself. Review of Resident #2's record showed there was not a Plan of Care developed for the use of the chair with tray 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 practitioner and case manager, if applicable.	A 162		

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A 162	Continued From page 2 (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. (f) A _____ 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 _____ 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 _____ 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,	A 162			

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A 162	Continued From page 3 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 _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference 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 _____ 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 _____, 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	A 162			

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A 162	Continued From page 4 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to have accurate health assessments for one out of seven sampled residents (Resident #1, Resident #5). The facility also failed to have a prescription and consent for the use of a _____ on 1 out of 6 sample residents (Resident #2). Findings included: 1. On _____ at 9:30 AM observed Resident #1 and Resident #5 walking using a walker under the staff supervision. A review of Resident # 1 record showed she had been admitted on _____. The health assessment completed on _____ stated the resident needed total assistance with all the activities of daily living. A review of Resident #5 record showed he had been admitted on _____. The health assessment completed on _____ stated the resident needed total assistance with all the	A 162			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALF FAMILY CARE II, CORP

**13480 SW 89TH TERRACE
MIAMI, FL 33186**

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A 162	Continued From page 5 activities of daily living. On _____ at 11:00 AM the Administrator stated the health assessments of Residents #1 and #5 were not accurate regarding their transferring and ambulation because both residents could walk supervised by staff with their walker. 2. On _____ at 7:00 AM observed Resident #2 sitting in a _____ chair with a tray that was restraining the resident. On _____ at 7:05 AM Staff B stated they use the tray to prevent resident stand up and adding the resident was unable to remove the tray by herself. Review of Resident #2's record showed there was not a prescription or a consent for the use of the _____ chair with tray _____. Class III	A 162		