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
	AL11968118	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLO HOGAR LIVING FACILITY	3406 WEST CARACAS ST TAMPA, FL 33614

(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 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ... the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical ..., the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately update medication observation records (MORs) each time medications were offered or given to two (Residents #1 and #3) of two sampled residents.	A 054		

AHCA Form 3020-0001

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

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A 054	Continued From page 1	A 054		

Findings Included:

A MORs review for Resident #1, conducted on , revealed that Resident #1's MORs had medications that were not documented as given to the resident which included , , , and C on at 03:00pm. On at 08:00pm, the medications , , , , , , and were not documented as given to Resident #1. On at 08:00am the medications , , , , , , , , , , , , , C, and were not documented as given to Resident #1. There were no times documented when Resident #1 received the resident's prescribed medication , 0.5mg take one tablet three time every day as needed for . It was documented that Resident #1 received the as needed , 0.5mg twice every day from . There was no documentation of the of Resident #1's MORs regarding the effects of the .

A MORs review for Resident #3, conducted , revealed that there were medications that were not documented as given to Resident #3 which included , 20mg from through at 08:00am and , 112mcg on at 06:00am.

During an interview with the Administrator, on at 11:45am, the Administrator agreed that Resident #1 and #3's MORs had medications that were not documented as given to the

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A 054	Continued From page 2 residents. Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must	A 056		

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A 056	Continued From page 3	A 056		

be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be

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A 056	Continued From page 4 kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to obtained an order for a change in the directions of use of medications for one Resident (#1). Furthermore, the facility failed to properly store medications in their original packaging with a medication label dispensed from a pharmacist for two Residents (#3 and #4) of three sampled residents. Findings Included: During an observation of the medication cabinet, conducted on at 12:35pm, it was observed that Residents #3 had eleven plastic medication cups that had no lids or medication labels. There were loose pills in each medication cup that were stacked inside each other and were toppled onto their side and the medications were spilling into the drawer. Resident #4 had five plastic medication cups that had no lids or medication labels. There were loose pills in each	A 056		

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A 056	Continued From page 5 medication cup that were stacked inside each other and were toppled onto their side and the medications were spilling into the drawer. A medication observation record review for Resident #1, conducted on , revealed that Resident #1's prescribed 2% shampoo was ordered to apply twice per week. The medicated shampoo was documented as given four times during the week of through on , , , and . The medicated shampoo was documented as given four times during the week of through on , , , and . Resident #1's prescribed D2 1.25mg take one capsule once every week on Tuesdays was documented as given every day from through . A record review for Resident #1, conducted on , revealed that there was no orders to change the application of the medicated 2% shampoo from two times per week to four times per week. There were no orders to change Resident #1's prescribed D2 from once per week to every day. During an interview with Administrator, conducted on at 11:45am, the Administrator agreed that medications had been pre-poured as much as six days in advance. The Administrator agreed that medications were supposed to stay in their original packaging with the medication label for each medication until dispensed. The Administrator agreed that there were no orders changing the directions of use for Resident #1's prescribed medicated shampoo and	A 056		

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A 056	Continued From page 6 D2. (photographic evidence obtained) Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not	A 078		

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A 078	Continued From page 7 constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence that employees were free	A 078		

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A 078	Continued From page 8 from ( ) annually for three employees (Administrator and Staff A and B). Furthermore, the facility failed to obtain a one-time statement that an employee was free from communicable within thirty days of employment for one employee (Staff A) of three sampled employees. Findings Included: An employee record review for the Administrator, conducted on , revealed that the Administrator's employee record contained a negative dated which was greater than one year ago. The Administrator was hired on . An employee record review for Staff A, conducted on , revealed that Staff A's employee record did not contain evidence that the employee was free from and did not contain a one-time statement that the employee was free from communicable within thirty days of employment. Staff B was hired on . An employee record review for Staff B, conducted on , revealed that Staff B's employee record contained a negative dated which was greater than one year ago. Staff B was hired on . During an interview with the with the Administrator, conducted on at 01:14pm, the Administrator agreed that the negative documents in her own record and in Staff B's record were obtained greater than one year ago. The Administrator agreed that Staff A's employee record did not contain evidence that the employee	A 078		

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A 078	Continued From page 9 was free from and did not contain a one-time statement that the employee was free from communicable within thirty days of employment. Class III	A 078		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for	A 084		

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A 084	Continued From page 10 control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;	A 084		

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A 084	Continued From page 11 i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of	A 084		

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A 084	Continued From page 12 medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed ensure that employees assisting residents with self-administration of medications had a six-hours training for assistance with self-administration of medications for one unlicensed Medication Technicians (Administrator) of three sampled unlicensed Medication Technicians. Findings Included: A medication observation record review for Resident #1, conducted on , revealed that the Administrator signed medications as given to Resident #1 from through which included , 150mg, 50mg, , 20mg, 10mg, , 75mg, 25mg, and , 112mcg. An employee record review for the Administrator, conducted on , revealed that the Administrator's employee record did not contain evidence that the Administrator completed a six-hours training for assistance with self-administration of medications. The Administrator was hired on .	A 084		

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A 084	Continued From page 13 During an interview with the Administrator, conducted on at 01:18pm, the Administrator agreed that her employee record did not contain evidence that she completed a six-hours training for assistance with self-administration of medications. The Administrator stated that it was her initials on Resident #1's medication observation record for documentation that medications were given to Resident #1. Class III	A 084		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable,	A 160		

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A 160	Continued From page 14 a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C.	A 160		

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	AL11968118	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 160	Continued From page 15 (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules	A 160		

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A 160	Continued From page 16 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 record review and interview, the facility failed ensure that former resident's dates of discharge or , reasons for discharge and places the residents were discharged to were noted in the admission and discharge log for three former Residents (#7, #8, and #9). Findings Included: A review of the admission and discharge log, conducted on , revealed that Resident #7 was admitted on . Resident #8 was admitted on . There were no dates of Residents #7 and #8's noted in the admission and discharge log. Resident #9 was admitted on . There was no date, reason, or place of discharge noted in the admission and discharge log. During an interview with the Administrator, conducted on at 01:40pm, the Administrator agreed that there were no dates of Residents #7 and #8's noted in the admission and discharge log. The Administrator agreed that Resident #9's date, reason, or place of discharge were not noted in the admission and discharge log. Class III	A 160		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must	A 162		

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A 162	Continued From page 17 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. (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	A 162		

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A 162	Continued From page 18	A 162		

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, 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

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A 162	Continued From page 19 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 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 record review and interview, the facility failed to execute a contract and obtain	A 162		

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A 162	Continued From page 20	A 162		

twice per year for one Resident (#1). Additionally, the facility failed to obtain a signed consent agreed to unlicensed Medication Technicians to assist with medications for two Residents (#1 and #5). Also, the facility failed to obtain health assessment forms that were documented on the required , form for three Residents (#1, #2, and #4). Furthermore, the facility failed to have residents' power of attorney and/or guardianship paper documented resident record for three Residents (#2, #3, and #5) of five sampled residents.

Findings Included:

A record review for Resident #1, conducted on , revealed that Resident #1 did not have a residency contract in the resident's record. There were no documented twice per year. There was no signed consent agreeing for unlicensed Medication Technicians to assist with medications. Resident #1's health assessment form dated was documented on the form and not the required , form. Resident #1 was admitted on .

A record review for Residents #2, conducted on , revealed that Residents #2's residency contract was signed by the resident's power of attorney. There was no power of attorney document in Resident #2's record. Resident #2's record did not contain a health assessment form. Resident #2 was admitted on .

A record review for Residents #3, conducted on , revealed that Residents #3's residency contract was signed by the residents' power of attorney. There was no power of attorney

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A 162	Continued From page 21 document in Resident #3's record. Resident #3 was admitted on . A record review for Resident #4, conducted on , revealed that Resident #4's health assessment form dated was documented on the form and not the required , form. Resident #4 was admitted on . A record review for Residents #5, conducted on , revealed that Resident #5's residency contract was signed by the resident's guardian. There were no guardianship documents in Resident #5's record. Resident #5's record did not contain a signed consent agreeing for unlicensed Medication Technicians to assist with medications. Resident #5 had no date of admission noted in the resident's record. During an interview with the Administrator, conducted on from 01:23pm through 01:45pm, the Administrator agreed that Resident #1, #2, and #4's health assessment forms were not documented on the required , form. The Administrator agreed that Resident #1's record did not contain a residency contract, , twice per year, and a signed consent for unlicensed Medication Technicians to assist with medications. The Administrator agreed that Resident #2's record did not contain a health assessment form. The Administrator agreed that Residents #2, #3, and #5's records did not contain power of attorney or guardianship documents for the persons that signed the residents' contracts. The Administrator agreed that Resident #5's record did not contain a consent agreeing to unlicensed Medication Technicians to assist with	A 162		

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A 162	Continued From page 22 medications. Class III	A 162		
CZ827	408.812 FS; 408.8065(3) FS Unlicensed Activity 408.812 Unlicensed activity.- (1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license. (2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients, and constitutes and neglect, as defined in s. 415.102. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency. (3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation, the person or entity is subject to penalties as prescribed by	CZ827		

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CZ827	Continued From page 23 authorizing statutes and applicable rules. Each day of operation is a separate offense. (4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance. (5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses, impose actions under s. 408.814, and regardless of correction, impose a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained or the unlicensed activity ceases. (6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules. (7) Any person aware of the operation of an unlicensed provider must report that provider to the agency. 408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.- (3) In addition to the requirements of s. 408.812, any person who offers services that require licensure under part VII or part X of chapter 400, or who offers skilled services that require licensure under part III of chapter 400, without obtaining a	CZ827		

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CZ827	Continued From page 24 valid license; any person who knowingly files a false or misleading license or license renewal application or who submits false or misleading information related to such application, and any person who violates or conspires to violate this section, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, Bello Hogar Assisted Living Facility failed to appropriately discharge 1 of 6 sampled residents (Resident #1) to a licensed facility. Furthermore, the Owner of Bello Hogar Assisted Living Facility was found to be operating an unlicensed assisted living facility by providing 3 of 4 unrelated persons (Resident #1, #2, and #3) with housing, meals and personal services to include assistance with medication and activities of daily living. Failure to ensure and maintain residents in a licensed location places residents at risk of harm, including and neglect. Findings Included: During an unlicensed activity complaint investigation (complaint 2024007557), completed from at 9:10 AM to at 4810 North Gomez Avenue, Tampa, FL 33614, a total of 4 residents were observed residing at the unlicensed facility.	CZ827		

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CZ827	Continued From page 25 On at 09:15am an attempted interview with Resident #1 revealed she was not communicative. An observation revealed Resident #1 had her personal belongings, products, clothing, medications, and a wheelchair in her room. On at 09:15am an interview was conducted with a home health agency nurse that was visiting Resident #1 at the time of the survey. The home health agency nurse stated that Resident #1 has resided at the unlicensed location for three years and received home health care services at the unlicensed location. She stated Staff that worked in the unlicensed facility gave Resident #1 assistance with medications and assistance with , grooming, ambulation, transferring, showering, and /toileting. On during an interview with Resident #2 at 09:20am, Resident #2 pointed at the staff and stated, they give me my meds and do her laundry. She stated the staff provided all the meals for the residents. She moved from a local nursing home and has lived at the unlicensed location for about 10 months. On during an interview with Resident #3 at 09:15am, Resident #3 was observed in her bed. She stated she received assistance with applying a brace, ambulation and transferring, , and showering. Resident #3 reported she has lived at the facility for the past 11 months.	CZ827		

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CZ827	Continued From page 26 During an interview with Staff B at the unlicensed location, conducted on at approximately 09:23AM, Staff B stated that she cooks three meals every day, does laundry and helps Resident #1 with her medications. Staff B stated the owner of the unlicensed location was [the owner of Bello Hogar Living Facility]. Staff identified all 4 fours residents as living at the unlicensed facility. During an interview with Staff C at the unlicensed location, conducted on at approximately 9:12 AM, Staff C stated that she cleans and does not provide care to the residents. Staff C stated Staff B cooks and gives medications to resident #1 and #2 and Staff B helps resident #2 and #3 with showers, bathing and . On during the investigation the unlicensed location staff were asked where resident medications were stored. An observation was made at 09:24am of Staff B opening the bottom of a four-drawer filing cabinet in the dining room just off the kitchen and retrieved the medication pill packs for resident #2. The medication packed had pharmacy labeling on the packaging. On at approximately 09:35am the Owner arrived at the unlicensed facility location. An interview was conducted with the Owner of the unlicensed location who refused to provide any documents for all four residents or the staff working in the unlicensed facility. The Owner	CZ827		

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CZ827	Continued From page 27 claimed she resided at the location but was not able to provide evidence that she resided in the location. The owner claimed that Residents #2 and #3 were her relatives but was unable to provide proof of any familial relation. On a telephone interview at 03:51pm with a Representative from Resident #1's home health agency was conducted. The Representative stated that the home health agency was asked by the Administrator to go to the unlicensed location's address to provide care and services to Resident #1. A background screening review, conducted on , revealed that the Owner's mailing address was at another location that was different from the unlicensed location and the licensed facility. The Agency Background screening clearing house also listed the unlicensed location Owner as the Chief Financial Officer, Owner/Operator and Administrator to several assisted living facilities including Bello Hogar Living Facility. On at 09:02am a telephone interview was conducted with a pharmacy representative using the contact information obtained from resident #2's pill pack. The pharmacy representative stated the pharmacy began sending medications to the unlicensed location in after the Owner requested the medications to be sent to the "ALF" [the pharmacy representative, identified the unlicensed location as an assisted living facility (ALF)].	CZ827		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLO HOGAR LIVING FACILITY	3406 WEST CARACAS ST TAMPA, FL 33614

(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
CZ827	Continued From page 28	CZ827		

On at 10:30am survey observations, interviews and record reviews were conducted at Bello Hagar Living Facility, a licensed assisted living facility, in relation to the unlicensed facility located 4810 North Gomez Avenue, Tampa, FL 33614. Observations revealed that Resident #1 had a bed, personal belongings, medications, and clothing at the licensed location. Resident #1 was not at the licensed location at the time of arrival. At 01:54pm, Resident #1 was observed being brought to the licensed location by an unknown male.

A review of the admission and discharge log, conducted on , revealed that Resident #1 was admitted to the licensed location on . Resident #1 was listed last on the running log after Residents #2, #3, #4, and #6 and former Residents #7, #8, and #9. Resident #2 was admitted on . Resident #4 was admitted on . Former Resident #7 was admitted on . Resident #6 was admitted on . Resident #3 was admitted on . Former Resident #8 was admitted on . Former Resident #9 was admitted on .

A record review for Resident #1, conducted on , revealed a health assessment form for Resident #1 was dated . The health assessment noted diagnoses of , with behavioral disturbances and . The health assessment noted Resident #1 required assistance with

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CZ827	Continued From page 29 medications and all activities of daily living (transferring, ambulation, bathing, , grooming, eating, and toileting). During an interview with the Administrator, conducted on at 1:50 PM the Administrator stated that Resident #1 had gone to the unlicensed location for adult day care services. The Administrator was unable to explain the reason the licensed facility sent Resident #1 to an unlicensed location for care and services. Unclassified	CZ827		
A 000	Initial Comments A complaint investigation (complaint number: 2024008363) and a generator monitoring were conducted at Bello Hogar Living Facility on . Deficiencies were identified at the time of 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	A 031		

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A 031	Continued From page 30	A 031		

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 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

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A 031	Continued From page 31 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 observation, record review, and interview, the facility failed to ensure that residents received third party services in the licensed assisted living facility for one Resident #1 of one sampled resident. Furthermore, the facility failed to ensure that third party providers followed the facility's policy and procedures to sign in and out of the facility and keep the Administrator of the home health care and services provided to one Resident (#1) of one sampled resident. Findings Included: During an observation at an undefined and unlicensed location, conducted on from 09:10am through 10:15am, Resident #1 was receiving home health care services at the undefined and unlicensed location. A review of the facility's undated third-party providers policy and procedures, conducted on	A 031		

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A 031	Continued From page 32 , the third-party provider policy and procedures noted that the third-party providers must sign in and out of the facility, and must keep the Administrator of the services being provided. An attempt to review the visitor sign in and sign out log, conducted on , revealed that there were no third-party providers that signed in and out on any day for Resident #1's home health care services that were rendered. A record review for Resident #1, conducted on , revealed that Resident #1 was admitted on . According to Resident #1's health assessment form dated , Resident #1 had a diagnosis of 's and alert and oriented times one. There was no evidence that Resident #1 received home health services in the resident's record. There was no evidence that the home health care agency kept the Administrator of the care and services that Resident #1 required. During an interview with the Administrator, conducted on at 01:50pm, the Administrator acknowledged that Resident #1 received home health care services at an unlicensed location on . The Administrator stated that Resident #1 went to the unlicensed location to receive adult day care. The Administrator agreed that the home health third party providers were not following the facility's policy and procedures to sign in and out each time they provided home health service for Resident #1. The Administrator was unable to provide evidence that the home health third party providers kept the Administrator of the care and services that	A 031		

Agency for Health Care Administration

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A 031	Continued From page 33 they provided to Resident #1. Class III	A 031		