

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 Chely's Care ALF Inc on 7/16/2024 & 7/17/2024. Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____, _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: The facility failed to provide daily observation by designated staff of the activities of the resident while on premises, and awareness of the general health, safety, and physical and emotional well-being of the resident one out of five (Resident #4) sampled residents. The facility failed to maintain a written record, updated as needed, of any significant changes or any illness for two out of five (Residents #1 and #3) sampled residents. Finding included: 1)	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 025	Continued From page 2 Observation on at 9:15 AM, showed Staff B and C were taking care of five residents. On at 9:18 AM, during the facility tour, the surveyor could not enter . . . # . . Resident #4 opened the door and did not allow the surveyor to enter her room. The surveyor observed a lot of clothes on the floor. On at 9:19 AM, Resident #4 stated "I cannot allow you to enter my room. I am . . . , my room is messy. I have a lot of clothes on the floor. I'm going to clean my room." On at 10:00 AM the residents received snacks. The staff did not offer snacks to Resident #4. On at 11:45 AM, the surveyor went to Resident #4's room and knocked on the door. Resident #4 opened the door, and the surveyor observed a person sitting in a chair inside the room. On at 11:47 AM, when asked who was the person that was sitting in her room Resident #4 stated that her cousin was visiting her. On at 11:49 PM, the person sitting in . . . # . . stated that she was visiting Resident #4. She added that Resident #4 was her friend. On at 12:10 PM, the Administrator stated Resident #4's friend came to visit her in the morning. She signed the visitor log. The residents were allowed to receive visitors and she could not control who visited them. On at 12:25 PM, the Owner stated	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 025	Continued From page 3 that she cannot control who visits the residents. Resident #4 received a lot of visitors in her room. She said that Resident #4's friend came around 8:00 AM today, and was in her room all the time. A review of the visitor log showed that Resident #4's friend arrived at 9:20 AM. A review of Resident #4's health assessment dated _____ showed the resident was diagnosed with _____, and _____ sleep _____. The physician indicated the resident was independent with all the activities of daily living. On _____ from 9:15 AM to 12:40 PM, the staff did not go to Resident #4's room to check on the resident. In addition, the surveyor did not observe Resident #4 or the visitor outside the room.	A 025		
2)	A review of the hospitalization log showed Resident #1 was transferred to the hospital on _____ and Resident #3 was transferred to the hospital on _____. A review of Resident #1's record showed she was admitted to the facility on _____. The record did not have documentation that her primary physician and family members were notified that the resident was transferred to the hospital on _____. A review of Resident #3's record showed she was admitted to the facility on _____. The record did not have documentation that her primary			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 025	Continued From page 4 physician and family members were notified that the resident was transferred to the hospital on On at 12:40 PM, the Administrator stated that Resident #1 was transferred to the hospital on because she was agitated, and Resident #3 was transferred to the hospital on because he was aggressive. Class III	A 025			
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure	A 034			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 034	Continued From page 5 documentation of each assistive device a resident uses must be included in the residents record for one out of six (Resident #3) sampled residents. Finding included: Observation on at 9:20 AM showed Resident #3 seated in a wheelchair and Staff C pushing the resident in the wheelchair from the patio area to inside the house. A review of Resident #3's records found no documentation the resident had an assistive device (wheelchair). Interviewed on at 1:20 PM, the Administrator confirmed that the wheelchair was not documented in the resident's records. Class III	A 034		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting	A 053		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 053	Continued From page 6 any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including _____ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that only licensed staff administered medications to one out of five (Resident #2) sample residents. Finding included: A review of Resident #2's Health Assessment dated _____ showed the resident was under hospice care. The resident required medication administration. A review of Staff B's employee record showed the staff completed the assistance with Self-Administration of Medication (6-hours)	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157			
(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 053	Continued From page 7 training course on _____ and three hours . The record also showed that Staff B was not a licensed healthcare provider. On _____ at 12:25 PM, Staff B stated that she administers the medications to Resident #2. Class III	A 053			
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 training may count toward the 2 hours of preservice orientation required under paragraph (a).	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 (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) 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	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 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. 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	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 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 observation, interview, and record review, the facility failed to provide a pre-service orientation of at least 2 hours for one out of three (Staff C) sampled staff. Findings included: at 9:15 AM, Staff B and Staff C were observed taking care of six residents. One of the residents was receiving hospice services. A review of the employee records revealed the facility did not have records available for Staff C, hired date was unknown. On at 10:20 AM, the Administrator stated that Staff C was hired yesterday.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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	A 081		
A 082 SS=D	Class III 59A-36.011(4) FAC Training - / (4) ... Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and ..., including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide a (/ training for one out of three (Staff B) sampled staff. Findings included: A review of Staff B's personnel record showed a hire date of . The record did not show / training. On . at 1:05 PM, the Administrator acknowledged Staff B's record did have the / training in file. Class III	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 SS=D	Continued From page 12 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: Based on observation, interview and record review, the facility failed to ensure a staff member who has completed courses in First Aid and . () and holds a currently valid card be in the facility all times. Finding included: On at 1:20 PM, Staff C was observed alone, taking care of five residents. A review of Staff C's employee record showed the () expired on	A 083 A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 13 On at 1:50 PM, Staff C confirmed that her training was expired. Class III	A 083		
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 fulfillment 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 control, and ensure unlicensed staff have adequately	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 084	Continued From page 14 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; i. Assist with _____; j. Use a _____ to perform _____ testing;	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 084	Continued From page 15 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 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	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 084	Continued From page 16 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 interview and record review, the facility failed to have two hours of required continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility for one out of three (Staff C) sampled staff. Findings included: A review of Staff C's record showed that the last six hours of medication training were dated A review of the resident's records showed that all current residents required assistance with self-administration of medications. On at 1:30 PM, Staff C stated she assisted the residents with medications. She confirmed that she did not receive the two hours of continuing education in medication. Class III	A 084			
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 093	Continued From page 17 and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 093	Continued From page 18 comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 093	Continued From page 19 (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow its menu during lunch. Findings included: On at 11:45 AM showed that the residents were served rice with black beans, shredded meat and potatoes and Jello. The residents did not receive mixed salad and fresh fruit. A review of the facility's menu prepared by the licensed dietitian on showed meat (4 ounces) with potatoes (. . . cup), and carrots (. . . cup), white rice (1 cup), mixed salad (1 cup), and fresh fruit (1). On at 1:10 PM, the Owner stated "We had the food catered for lunch but they did not	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 093	Continued From page 20 send the salad and fresh fruit."	A 093			
A 162 SS=D	Class III 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. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER CHELY'S CARE ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10841 CORAL REEF DR MIAMI, FL 33157		
(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 162	Continued From page 21 (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, 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	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 162	Continued From page 22 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 arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELY'S CARE ALF INC

**10841 CORAL REEF DR
MIAMI, FL 33157**

(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 162	Continued From page 23 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney (POA) for two out of six (Resident #2 and #3) sampled residents. The facility failed to have a completed health assessment for one out of six (Resident #1) sampled residents. The facility failed to ensure all required demographic data was included in the records of two out of six (Resident #1 and #2) sampled residents. Findings included: A review of Resident #2's and #3's records showed a contract dated _____ signed by their sons. There was no documentation resident had an _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney (POA) in file. A review of Resident #1's health assessment did not indicate the date that the assessment was completed. A review of Resident #1's and #2's records showed the demographic sheet missed the information of the resident's family members or legal representatives to be notify in case of an emergency. . On _____ at 1:00 PM, the administrator stated the facility did not have documentation of Resident #2's and 3's health care surrogate, health care proxy, guardian, or power of attorney. The administrator confirmed that Resident #1's health assessment was incomplete. She stated she would add the missing demographic data.	A 162		

If continuation sheet 25 of 25