

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOME CARE FACILITY INC

**6960 SW 155 AVE
MIAMI, FL 33193**

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

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 1 qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 2 obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 3 to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 4 relating to retaining _____ pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any _____ person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any _____ person that would place the employee in a role that requires background screening unless the employee is granted an	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 5 exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been _____ for a disqualifying offense, the employer must remove the employee from contact with any _____ person that places the employee in a role that requires background screening until the _____ is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with _____ persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including _____, if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or _____ for a disqualifying offense listed under this chapter,	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
CZ815	Continued From page 6 terminates the person against whom the report was issued or who was _____, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure staff who provide personal care to the residents or have access to residents living areas had a Level 2 Background screening conducted through the agency (Staff C). Findings as follow: On _____ at 7:45 AM Staff C was observed cleaning the facility and walking freely through the residents' common areas and rooms. Staff C was also seen assisting residents to transfer and to reposition on the chairs. Review of the background screening database showed there was not a background screening conducted for Staff C. On _____ at 8:50 AM the Administrator stated Staff C was not a facility employee and she was the private companion of a Day Care (#5) adding "I have told [Staff C] that she cannot assist residents in their activities of daily living" unclassified	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments A complaint investigation (Complaint #2024010776) visit was conducted at American Home Care Facility Inc from _____ to _____. The provider had deficiencies at the time of the visit.	A 000			
A 030 SS=D	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030			

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: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____. 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical _____. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making _____ for health care services, the provision of or arrangement of transportation to health care _____, and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally _____, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to treat one out of four Day Cares with consideration and respect (\$5). Findings as follow: On at 7:45 AM observed . . . # . . . had 2 beds and 1 folding bed in the middle of the room.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 030	Continued From page 6 On at 1:05 PM The Administrator stated Day Care residents used the beds in . . . #. to rest and that the folding bed was where staff slept at night. On at 8:35 PM (off hour visit) it was observed in . . . #. Day Care #5 sleeping in the folding bed placed between beds. The right side bed was not occupied. Class III	A 030			
A 052 SS=D	429.256(. . .); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 052	Continued From page 7 (c) Placing an oral dosage in the resident's _____ or placing the dosage in another container and helping the resident by lifting the container to his or her _____ (d) Applying _____ medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____ (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 052	Continued From page 8 or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 052	Continued From page 9 resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOME CARE FACILITY INC

**6960 SW 155 AVE
MIAMI, FL 33193**

(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 052	Continued From page 10 failed to assure staff followed the correct procedure when assisted two out of four residents with self-administration of medications (Residents #2, #3). Findings as follow: On at 7:45 AM Staff B was observed when assisted resident #2 with self-administration of medications POT 100 mg. 1 tab oral daily 7 am, Rosuvastatin 1 tab oral daily 7 am. Resident was sitting at the dining table taking breakfast. Staff was not observed washing wash , she did not prompt medications to the resident. Staff dropped the pills in a cup, placed it in front of the resident and left to residents' rooms, resident was not observed when taking medications. Then staff came , signed the Medication Observation record and returned medications to the cabinet. On at 7:48 AM stated "It is difficult, with this resident. I do not prompt medications to her because she speaks English and I do not". On at 9:50 AM Staff B was observed when assisted Resident #3 with self-administration of 7:00 AM medications , Meloxicam 15 mg tab, 10 mg, 81 mg, 40 mg, 40 mg, 300 mg, C 1000 mg. Staff was not observed washing her and she did not prompt medications to the resident. On at 9:50 AM Staff B stated "I do not prompt medication to Resident #3 because she is hard of hearing and I am giving medications late because she likes to sleep and I cannot force her to wake up early".	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 052	Continued From page 11 On _____ at 12:41 PM the Administrator stated "Resident #3 did not take medications at time scheduled, because we cannot force the resident to take medications early" Review of Staff B's record showed she had received the 6-hour medication training on _____. Class III	A 052			
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	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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	Continued From page 12 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 observation, record review and interview the facility failed to maintain an accurate daily medication observation record for one out of four residents (Resident #2) who receives assistance with self-administration of medications. Findings as follow: On _____ at 7:50 AM it was observed Staff B assisting Resident #2 with self-administration of medications. Review of Resident #2's medication observation record showed on _____ the resident was ordered _____ D2 50000 units. 1 Tab oral once a week. Further review showed the medication was signed as given daily from _____ to _____. On _____ at 7:50 AM Staff B stated "I give the medications to residents as prescribed, maybe it was signed those days by mistake". Class III	A 054			
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL.	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 055	Continued From page 13 (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 055	Continued From page 14 requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 055	Continued From page 15 by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assure medications were secured all the time. Findings as follow: On at 7:35 AM It was observed in the facility's dining room Resident #2 taking breakfast. Over the dining table the dining table and, in front of the resident was a box containing medication of B2- 5000 units, Rosuvastatin 40 M, POT 100 mg, Tart 5 mg. It was seen Staff B walking to the Florida room to assist another resident and the medication box left in front of the resident unattended. When finished staff returned and assisted the resident with self administration of medications. On 0820/2024 at 8:00 AM Staff B stated she left the medication box with Resident #2 for a moment to assist a resident in the Florida room. On at 10:20 AM the Administrator stated staff knows well tht medications must be secured all the time. Class III		A 055		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff		A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 078	Continued From page 16 (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 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	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 078	Continued From page 17 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 that provides 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 have a statement from a healthcare provider documenting freedom from _____ () within 30 days of employment for one out of five staff (Administrator) and it failed to have freedom from _____ documented on annual basis for one out of five staff (Staff E). Based on interview and record review the facility failed to ensure that two out of five sample staff are qualified to perform their assigned duties consisting in their level of education, preparation, training and experience (Staff B and E) Findings as follow:	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 078	Continued From page 18 Review of the record of Administrator hired on _____ showed there was not a statement from a healthcare provider documenting he was free from _____. Review of the record of Staff E hired on _____ showed the freedom from _____ statement available for review was dated _____. On _____ at 1:00 PM the Administrator stated his free from _____ statement was misplaced adding he had not realized Staff E's _____ statement was expired. On _____ at 8:10 AM Staff E was asked to explain the _____ (_____) and she said "I give 10 _____ on the _____ and this is it". On _____ at 8:20 AM Staff B was asked to explain the _____ and she said "We move the _____ on _____, I don't know well". On _____ at 8:21 AM Staff B was asked to explain what do not _____ order (_____) was and she stated "The resident tells you, if can talk". Review of Staff E record showed she received the _____ training on _____. Review of Staff B record showed she received the _____ training on _____ and the _____'s training on _____. On _____ at 1:10 PM the Administrator stated Staff B and E did train in _____ and _____'s but get nervous when interviewed. Class III	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024																						
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193																									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE																						
A 079	Continued From page 19	A 079																									
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents, Day Care Participants, and Respite Care Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td></td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> <tr> <td>46-55</td> <td>375</td> </tr> <tr> <td>56-65</td> <td>416</td> </tr> <tr> <td>66-75</td> <td>457</td> </tr> <tr> <td>76-85</td> <td>498</td> </tr> <tr> <td>86-95</td> <td>539</td> </tr> </table> For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168		212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079			
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																										
0-5	168																										
	212																										
16-25	253																										
26-35	294																										
36-45	335																										
46-55	375																										
56-65	416																										
66-75	457																										
76-85	498																										
86-95	539																										

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 079	Continued From page 20 must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least () must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 079	Continued From page 21 meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 079	Continued From page 22 minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to meet the required staffing hours to meet residents' scheduled and unscheduled needs. Findings as follow: On at 7:35 AM observed in facility Staff B and Staff D assisting 4 residents and 4 day cares with the activities of daily living. On at 7:35 AM Staff B stated Staff D did not work in facility and she was only the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOME CARE FACILITY INC

**6960 SW 155 AVE
MIAMI, FL 33193**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 23 private aid of Resident #7 adding the Administrator was working that morning with her but he went to the grocery store to buy rice. On at 7:55 AM observed Staff D going to residents rooms, getting his purse and leaving the facility. Staff B remained alone in facility assisting the 4 residents and 4 day care participants. On at 8:05 AM arrived Staff E and at 8:38 AM arrived the Administrator. Class III	A 079		
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietitian, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have the person designated as responsible for the facility's food service	A 085		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOME CARE FACILITY INC

**6960 SW 155 AVE
MIAMI, FL 33193**

(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 085	Continued From page 24 (Administrator) trained annually in a minimum of 2 hours in topics pertinent to nutrition and food service. Findings as follow: Review of staffing records showed there was not an updated Nutrition and Food service training for the Administrator. The training available for review was dated On 0821/2024 at 1:00 PM the Administrator stated he was in charge of buying the food supplies adding "I was here this morning, but I had to go to the store to buy rice". Class III	A 085		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 161	Continued From page 25 from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to failed to maintain staff record available to the agency for one out of five staff (Staff D) and failed to maintain personnel	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 161	Continued From page 26 records for two out of five staff members containing the Attestation of Complianace with the background screening (Administrator, Staff C). Findings as follow: On at 7:35 AM observed Staff D cleaning the facility, walking freely through residents' common areas and rooms and assisting residents with the activities of daily living. Review of facility's records showed there was not a staffing record available for Staff D containing an application for employment and trainings. Review of the Administrator (hired on) and Staff C (hired on)'s records showed there was not a copy of the attestation of Compliance with the background screening available. On at 1:15 PM the Administrator stated Staff D was not a facility employee but she was the private companion of resident #7. The Administrator acknowledged the Attestation of Compliance with the Background screening form was not in his and Staff C's records. Class III	A 161			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. . . .	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 27 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. (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	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 28 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 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.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER AMERICAN HOME CARE FACILITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6960 SW 155 AVE MIAMI, FL 33193		
(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 29 (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 observation, record review and interview the facility failed to have documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one out of four residents (Resident #1) and two of four Day Cares (#6 and #7). Findings as follow: On _____ at 7:45 AM it was observed	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOME CARE FACILITY INC

**6960 SW 155 AVE
MIAMI, FL 33193**

(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 30 Resident #1 and Day Care participants #6 and #7 in the facility. Review of Resident #1 Agreement between the resident and the facility showed it was executed by a family member on _____. Review of Day Care participants #6 and #7 showed their agreements for care were signed by family members on _____ and _____ respectively. Review of Resident #1's and Day Care participants #6 and #7's records showed there were not copies of a Power of Attorney for the residents. On _____ at 1:30 PM the Administrator acknowledged Resident #1' and Day Care participants #6 and 7's families had not provided the facility with the Power of Attorney for them. Class III	A 162		