Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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
{CZ814}	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	{CZ814}		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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
{CZ814}	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report the change in status of 2 out of 2 sampled employees (Staff D and Staff E). Staff D had been terminated in 2024, and Staff E was not listed on the facility roster. Findings included: Observation on at 10:35 AM showed that Staff E was working alone and there were 4 residents admitted to the facility. A review of the facility roster revealed that Staff E was not listed. Interviewed on at 10:40 AM Staff E stated that she was the only employee at the facility and that she was hired on as a live-in employee. Staff E further stated that there were no other staff members, and she did not know who Staff D was.	{CZ814}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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
{CZ814}	Continued From page 2 A review of the facility roster revealed that Staff D was listed as active with a hire date of . Unclassified	{CZ814}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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: 1. Does not have an active professional license or certification from the Department of Health; or 2. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 ensure that 1 out of 1 sampled caregiver that was caring for residents had an eligible level II background screening (Staff E) Findings included: Observation on at 10:35 AM showed that Staff E was working alone and there were 4 residents admitted to the facility. A review of the Background Screening showed that Staff E was not listed on the facility roster. Further review revealed that Staff E did not have a level 2 background screening. Interviewed on at 10:40 AM Staff E stated that she was the only employee at the facility and that she was hired on as a live-in employee. Staff E restated that there were no other staff members. Interviewed on at 10:48 AM Staff E stated that she did not have documentation of a level 2 background screening. When she was asked if she ever had a background screening	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 7 Staff E stated that she had a police report, but she did not have documentation for it or any other documents on her person. A review of facility records showed no documentation of a level 2 background screening for Staff E. Unclassified	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 second revisit to a re-certification survey was conducted at High Tower ALF from through . New and uncorrected deficiencies were identified at the time of the survey.	{A 000}		
{A 010} SS=J	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	{A 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	{A 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	{A 010}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	{A 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the continued appropriateness of residency for one of four sampled residents (Resident 2) Resident 2 was bedbound and legally , was unable to move, required 'as-needed' and medication administration. Findings included: A review of Resident 2's progress notes dated showed that he had great difficulty breathing, was unable to eat or take his medicines, was given treatments but was not transferred to the hospital until the following day via emergency service on treatment when a visiting nurse found him unresponsive and unable to move. Further review of Resident 2's progress note dated showed, "On Saturday, the patient was transferred to [Hospital] According to the staff the day before the patient could not finish his meal due to and she administered the several times on that same day. The next day, , the patient could not take the medications because he would not respond to any stimuli, he could not eat his breakfast either. When the nurse came to administer the injectable , he was not responsive and with the help of the Staff they had to turn him on the bed to administer the injectable medication. Observing the patient's state the Staff called 911 at 10:02 AM. Rescue arrived at 10:11 AM, they evaluated him and noticed that he continued with great difficulty breathing and he	{A 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 5 was transferred on to [Hospital] at 10:20 AM." Observation on at 10:45 AM showed that Resident 2 was on a hospital bed awake, with his closed. The resident was unable to speak. Further observation revealed that the resident was unable to walk or exit the bed without staff assistance. Interviewed on at 10:38 AM Staff E stated that a nurse visited Resident 2 once a week. When asked, Staff E stated she did not know what hospice care was. Staff E stated, "He [Resident 2] can't speak, he can only say a word or two. A nurse comes to see him once a week" Observations on from 11:00 AM through 11:50 AM showed that Resident 2 had a severe and seemed to have . Further observation showed that Staff E used a suction machine to suction phlegm from the Resident's and a for an aerosol treatment. A review of Resident 2's hospice clinical summary dated through showed, "Orders: Teach use. Provide education to caregivers regarding how to identify signs of to report to the care team (, coughing, whizzing) Teach precautions to all caregivers. Medications: ( ) 2 liters per minute inhalation PRN (as needed for) " Interviewed on at 11:55 AM when she was asked how she knew if the Resident needed Staff E stated that she only gave the resident treatments. Staff E stated, "I use the pump for the phlegm [ ] and give	{A 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 6	{A 010}		

him the aerosol [ ] 3 times a day. I make sure the bed is lifted, and I give him his medicines too"

When asked when she used the concentrator and the portable tank that were in Resident 2's room Staff E stated "I don't know what that is. I have never used it. I give him aerosol"

A review of Resident 2's health assessment dated showed a medical history and diagnoses of unspecified 's , legally ( ), mixed , , OA ( ) The physical limitations showed legally /bedbound. The status showed AAOX1 (alert, oriented to person) poor verbal. The nursing requirements showed hospice care. Special precautions were , and precautions. The activities of daily living (ADL) showed he needed total care with all ADLs, ambulation, bathing, , eating, self-care, toileting and transferring. Diet instructions were puree diet, thickener added to liquids. The Resident was bedridden. Needed medication administration, crushed medication, open capsule.

Interviewed on at 1:20 PM the Hospice Nurse stated that she visited Resident 2 once a week and he had had orders for PRN (as needed), but she did not administer his medications. When she was asked how the facility staff would know when the Resident needed treatment the Hospice Nurse stated. "They will call me if they need anything, and I can come in."

Observation on at 10:35 AM showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 010}	Continued From page 7 that Staff E was working alone and there were 4 residents admitted to the facility. Interviewed on at 10:40 AM Staff E stated that she was the only employee at the facility and that she was hired on as a live-in employee. Staff E further stated that there were no other staff members. Interviewed on at 10:42 AM when asked if she had First Aid, , , ( ) or medication training Staff E stated that she did not. Staff E stated, "No I don't have that. I don't want to lie. I don't know how to do " Staff E further stated that she could not provide documentation for a negative test report, emergency management, food service, control training or a pre-service orientation. Staff E stated, "I don't know if there are any records here." Class 1	{A 010}		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation.	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 027	Continued From page 8 (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to facilitate access to health care for 1 out of 4 sampled residents (Resident 3). The facility failed to coordinate a medical , , and transportation service for an (test) and an lavage procedure for Resident 3. Resident 3 never had the test and missed his , , for the lavage. Findings included: Observation on at 10:35 AM showed that physician's orders for an test and lavage for wax removal of , cerumen in both as well as an , , card dated at 9:15 AM for an wash for Resident 3 were on top of the visitor's sign-in sheet in the living room (Photographic evidence obtained) Interviewed on at 10:40 AM when asked if the Resident had kept his , , and if the test was scheduled Staff E stated," I already took care of that" Interviewed on at 3:45 PM when asked if the test and the lavage were done Resident 3 stated, "No, I am still waiting. I don't know when I am going to get it done." Class II	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 9	A 030		
A 030 SS=L	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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 10 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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 11 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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 12 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 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.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 13 (l) 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 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.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 14 429.27 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, interview and record review the facility failed to ensure that 4 out of 4 sampled residents (1, 2, 3 and 4) received adequate care. Resident 2 was bedridden, legally , unable to communicate, had difficulty breathing and needed prescribed . Resident 5 had a and suffered a , but emergency services were not notified until hours later. Resident 1 had , and a fecal impaction but went without medical care for several days before she was hospitalized with . Resident 3 was , needed daily administration and did not receive his treatment on time. Findings included:	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 15 Resident 2) Observation on at 10:45 AM showed that Resident 2) was on a hospital bed awake, with his closed but could not speak. Interviewed on at 10:46 AM Staff E stated, "He [Resident 2] can't speak, he can only say a word or two. A nurse comes to see him once a week" Observations on from 11:00 AM through 11:50 AM showed that Resident 2 had severe and appeared . When asked when she used the concentrator and a portable tank that were in Resident 2's room Staff E stated "I don't know what that is. I have never used it. I give him aerosol" A review of Resident 2's hospice clinical summary dated through showed, "Orders: Teach use. Provide education to caregivers regarding how to identify signs of to report to the care team (, coughing, whizzing) Teach precautions to all caregivers. Medications: ( ) 2 liters per minute inhalation PRN Interviewed on at 11:55 AM when she was asked how she knew if the Resident needed Staff E stated that she only gave him treatments. Staff E stated, "I use the pump for the phlegm [extract] and give him the aerosol [ ]. I make sure the bed is lifted. I give him his medicines too"	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 16 A review of Resident 2's health assessment dated showed a medical history and diagnoses of unspecified , 's , legally , ( ), mixed , , , OA ( ) The physical limitations showed legally /bedbound. The status showed AAOX1 (alert, oriented to person) poor verbal. The nursing requirements showed hospice care. Special precautions were , and precautions. The activities of daily living (ADL) showed he needed total care with all ADL, ambulation, bathing, , eating, self-care, toileting and transferring. Diet instructions were puree diet, thickener added to liquids. The Resident was bedridden and eeded medication administration, and crushed medication, open capsule. A review of Resident 2's most recent progress notes (translated from Spanish) showed: - "On Saturday, the patient was transferred to [Hospital] According to the staff the day before the patient could not finish his meal due to and she administered the several times on that same day. The next day, , the patient could not take the medications because he would not respond to any stimuli, he could not eat his breakfast either. When the nurse came to administer the injectable , he was not responsive and with the help of the Staff they had to turn him on the bed to administer the injectable medication. Observing the patient's state the Staff called 911 at 10:02 AM. Rescue arrived at 10:11 AM, they evaluated him and noticed that he continued with great difficulty breathing and he was transferred on to [Hospital] at 10:20 AM." - "On [the Resident] was	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 17 received at the ALF at 4:00 PM. The patient was discharged from [Hospital] on that same day, with a treatment of medications which was communicated to the ALF staff. Today at 11:30 AM [the Resident] was visited by his doctor and she found him stable and responding to medications." According to the Mayo Clinic, " is a condition caused by damage to the . The damage results in and irritation, also called inside the airways. Symptoms include trouble breathing and that brings up . People with have damage to their that makes it harder to breathe. is the most common symptom of " Resident 5) Interviewed on at 10:55 AM Staff E stated that Resident 5 was in the hospital because she had a on when going to the toilet alone. Staff E further stated that she did not call the doctor but notified the Resident's daughter via text message and called emergency services hours later when a family member that had arrived at the facility told her to do it. Interviewed on at 10:55 AM Staff E stated, "[Resident 5] is in the hospital. She on Saturday. I was in the kitchen washing the dishes when I heard [Resident 5] calling me and I found her on the bathroom floor; her wheelchair was in the hallway. She was complaining of in her . I think that she dropped her soap and tried to pick it up. I put her in the wheelchair, took her to her room and put her to bed. It was hard because she was heavy. I sent a text to her daughter, but she did not answer right away.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: ______ B. WING ______	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 18	A 030		

Later I when I talked to her daughter again, she told me to call her brother-in-law if she still had , during the night. I called her daughter to tell her that [Resident 5] was in , , and her brother-in-law came in at around 8:00 PM. He told me to call 911. I called 911, and they came and took her to [Hospital]. She is still there. [Resident 5] has been in the hospital before, at least 3 times. One time she passed out like she was . I called 911 and her daughter also. They took her to the hospital, and her daughter said that she needed ."

A review of Resident 5's hospital record dated through showed " female with past medical history of on , non- , , and history of , who presented to the Emergency Department via ambulance after a mechanical at her ALF ambulating when trying to transfer from the wheelchair to the toilet. Patient states that she went to use the restroom and . Patient was admitted to the hospital for right , and underwent left , ."

According to the Cleveland Clinic, a is a serious injury that requires immediate medical care. A , hemi , is a surgical procedure to treat , when the of the is damaged replacing half of the , with a , "

A review of Resident 5's incomplete health assessment (missing page, date unknown) showed medical history and diagnoses of

history of , , , , status post right , ORIF (open reduction and internal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 19) right , . The physical limitations showed ambulatory limitations. The status showed , with behavioral disturbances. The nursing requirements showed needed assistance with ADLs (activities of daily living). Special precautions were and , precautions. The ADL assessment showed needed assistance with all ADLs (ambulation, bathing, , eating, self-care, toileting, transferring) Resident 1) Interviewed on at 11:00 AM Staff E stated that Resident 1 was in the hospital because she could not defecate for several days. Staff E further stated that she extracted an , from the Resident's body before she was transferred to the hospital. Staff E further stated that she had not called the doctor but had told a family member. Staff E stated, "She could not defecate for days. She was blocked. Feces, hard as a rock. But I helped her, and I was able to pull it out. I told her family; they sent her to the hospital; she is still there" According to the Cleveland Clinic, "Constant and untreated , can cause fecal impaction. A fecal impaction is the result of constant , when feces are stuck inside the . Fecal impaction is common in the elderly, and it is preventable" A review of Resident 1's hospital discharge records dated showed that she presented at the emergency department via [Emergency Services] complaining of severe , on the left side for 3 days, and _ for 1 day. The daughter at bedside stated that the patient lives in a facility and she	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 20 was notified that the patient has not had movements for the past 3 or 4 days and was complaining of , . The patient was evaluated by , regarding the finding of a T12 that was discovered on her CT of the abdomen with an acute appearance as compared to a prior CT from 7 months ago. The patient was admitted due to 4 days of , and being treated for and was discharged with diagnoses of acute , , AKI (acute , injury) , , , elevated lactic level, of 12th , , , pre- . A review Resident 1's health assessment dated showed medical history and diagnoses of . pre- , AKI (resolved. Acute , injury) The physical limitations section was left blank. The status showed baseline , disoriented to time and place. , . The nursing requirement section was left blank. precautions were indicated. The ADLs showed she needed assistance with all ADLs (ambulation, bathing, , eating, self-care, toileting, transferring). Special diet instructions were soft , , , ground, minced and moist. Calories controlled. Needed assistance with self-administration of medicine. Observations showed follow up with PCP in 2 to 4 days. Further review of Resident 1's record showed no documentation that a health care provider had been notified about the Resident's condition. Resident 3) Observation on at 10:35 AM showed a physician's order for an and lavage for	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 21 wax removal of , cerumen in both and an , , card dated at 9:15 AM for an wash for Resident 3 on top of the visitor's sign-in sheet in the living room. Interviewed on at 10:40 AM when asked if Resident 3 had kept his , , Staff E stated," I already took care of that" Interviewed on at 3:45 PM when asked if he had the test and the lavage Resident 3 stated, "No, I am still waiting. I don't know when I am going to get it done." A review of Resident 3's health assessment dated showed medical history and diagnoses of , Type II long term/current use, , high , , , , of the , . Physical limitations showed abnormality of gait and mobility/ use of walker. status showed alert and oriented to person, time and place. Nursing requirements showed daily administration. Special precautions were universal and precautions. The activities of daily living (ADL) showed needed supervision with bathing, , eating, self-care and toileting, independent with ambulation and transferring. Needed assistance with pill medications and administration of . Class I	A 030		
A 031 SS=H	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 22 prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 23 whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to coordinate services and maintain documentation of communications with third party service providers regarding the care of 2 out of 4 sampled residents (Residents 2 and Resident 3) Findings included: Resident 2) Observation on at 10:45 AM showed that Resident 2 was on a hospital bed awake with his , closed and could not speak.	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 24 Interviewed on at 10:46 AM Staff E stated, "He [Resident 2] can't speak, he can only say a word or two. The [Hospice] nurse comes to see him once a week" Observation on from 11:00 AM through 11:50 AM showed that Resident 2 experienced severe and Observation on at 11:30 AM showed that Staff E used the hospital bed's remote control to lift the resident torso and stated, "I lift him up to help him breathe" Further observation showed that Staff E used a suction machine and a probe to suction phlegm from the Resident's A review of Resident 2's hospice clinical summary dated through showed, "Orders: Teach use. Provide education to caregivers regarding how to identify signs of to report to the care team (, coughing, whizzing) Teach precautions to all caregivers. Medications: ( ) 2 liters per minute inhalation PRN Interviewed on at 11:55 AM when she was asked how she knew if the Resident needed Staff E stated that she gave him treatments. "I use the pump for the phlegm and give him the aerosol. I make sure the bed is lifted. I give him his medicines too" When asked when she used the concentrator and a portable tank to provide treatment to Resident 2 Staff E stated "I don't know what that is. I have never	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 25 used it. I give him aerosol [ ]" Interviewed on at 1:20 PM the Hospice Nurse stated that Resident 2 had orders for PRN (as needed). When she was asked how the facility staff would know when the Resident needed treatment the Hospice Nurse stated. "They will call me if they need anything, and I can come in. She doesn't need to be qualified, anybody can give , the family can do it" A review of Resident 2's record showed he had last been since the PCP (Primary Care Provider) 2 months before, on . A review of Resident 2's health assessment dated showed a medical history and diagnoses of unspecified 's , legally , ( ), mixed , , , OA ( ) The physical limitations showed legally /bedbound. The status showed AAOX1 (alert, oriented to person) poor verbal. The nursing requirements showed hospice care. Special precautions were and precautions. The activities of daily living (ADL) showed he needed total care with all ADLs, ambulation, bathing, eating, self-care, toileting and transferring. Diet instructions were puree diet, thickener added to liquids. The Resident was bedridden. Needed medication administration, crushed medication, open capsule. A review of Resident 2's progress notes dated showed, "On Saturday was transferred to [Hospital] According to the staff the day before the patient could not finish his meal due to and she	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 26 administered the several times on that same day. The next day, , the patient could not take the medications because he would not respond to any stimuli, he could not eat his breakfast either. When the nurse came to administer the injectable , he was not responsive and with the help of the Staff they had to turn him on the bed to administer the injectable medication. Observing the patient's state the Staff called 911 at 10:02 AM. Rescue arrived at 10:11 AM, they evaluated him and noticed that he continued with great difficulty breathing and he was transferred on to [Hospital] at 10:20 AM." Further review showed no documentation of communication with the hospice regarding Resident 2's condition. Resident 3) A review of Resident 3's record showed doctor's orders for daily monitoring and administration of 100 ml 15 units sq daily for Type II, long term and current use. A review of Resident 3's medication observation record (MOR) showed, "Administer once a day at 8:00 AM- 100 units vial, 15 units." Further review of Resident 3's MOR showed no documentation that had been administered on and on . (Photographic evidence obtained) Further review of Resident 3's record showed no documentation that the Resident's level had been monitored or that had been administered on and on .	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 27 Interviewed on at 10:35 AM Staff E stated that a nurse came to administer to Resident 4 in the afternoon. Staff E stated, "She signs the medication book Sometimes she comes in the morning." Interviewed on at 4:00 PM when asked about Resident 3's missing level readings and administration, the Home Health Agency Nurse stated that she had done it, but she had not signed the MOR. When she was asked why she had arrived at 4:00 PM to administer the to the Resident the Home Health Nurse stated that sometimes she would come in the mornings, but she had many other patients in distant locations, and she could not always make it at that time and because the Resident went to daycare in the morning. A review of Resident 3's records showed that he had last seen his PCP on , more than 2 months prior. A review of Resident 3's health assessment dated showed medical history and diagnoses of , Type II long term/current use, , high , of the , . Physical limitations showed abnormality of gait and mobility/ use of walker. status showed alert and oriented to person, time and place. Nursing requirements showed daily administration. Special precautions were universal and precautions. The activities of daily living (ADL) showed needed supervision with bathing, , eating, self-care and toileting, independent with ambulation and transferring. Needed assistance with pill medications and administration of .	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 28 Further review showed no documentation that the facility had communications with the home health service provider regarding inconsistent timing of the administration and the missing level monitoring and administration for Resident 3. Class II	A 031		
{A 052} SS=F	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. (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	{A 052}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 29 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 or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	{A 052}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 30 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 resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	{A 052}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 31 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, interview and record review the facility failed to ensure that 1 out of 1 sampled unlicensed staff member was trained to assist the residents with self-administration of	{A 052}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 32 medication (Staff E) The facility also failed to ensure that medications were given to the residents at their scheduled time. Findings included: Observation on at 10:35 AM showed that Staff E was working alone and there were 4 residents admitted to the facility. Interviewed on at 10:40 AM Staff E stated that she was the only employee at the facility and that she was hired on . Interviewed on at 10:42 AM when asked if she had medication training Staff E stated that she did not. Staff E stated, "No I don't have that. I don't want to lie" A review of facility records showed no documentation of training on Assistance with Self-Administration of Medication for Staff E. Interviewed on at 10:39 AM Staff E stated that she had given the morning medications to the residents, and she had also signed the MOR (Medication observation record) Staff E further stated that she also administered inhalation treatments to Resident 2 three times per day. A review of resident records revealed that Staff E had signed the Medication Observation Record for Residents 2, 1, 3 and 5. Resident 2} Observation on at 11:45 AM showed that Staff E used a suction machine to suction phlegm from Resident 2's .	{A 052}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 33 Interviewed on at 11:55 AM Staff E stated, "I use the pump for the phlegm [extract] and give him the aerosol [ ]. I give him his medicines too" Further observation showed that Staff E administered an inhalation treatment of , , 0.02% solution using a machine to Resident 2. Resident 3) A review of the MOR showed that Resident 3's daily 8:00 AM injections of 15 units of on and on , were not signed. Interviewed on at 10:40 AM Staff E stated that a nurse administered the to Resident 3, but she was coming in the afternoon. Staff E stated," Sometimes she comes in in the morning" Observation on at 4:00 PM showed that the Home Health Nurse arrived at the facility to administer to Resident 3. Interviewed on 01.22/2025 at 4:05 PM when asked why the Resident did not receive the at 8:00 AM as ordered Nurse Marlene stated that she had a long route of patients to visit and that the Resident also went to daycare on some days. Class III	{A 052}		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration	A 053		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 34 (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 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:	A 053		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 35 Based on observation, interview and record review the facility failed to ensure that 1 out of 1 sampled staff was licensed to administer medications (Staff E) Findings included: Observation on at 10:45 AM showed that Resident 2 was on a hospital bed awake, with his closed but could not speak. Interviewed on at 10:46 AM Staff E stated, "He [Resident 2] can't speak, he can only say a word or two. A nurse comes to see him once a week" Observation on at 11:50 AM showed that Staff E fed Resident 2 thickened water and pureed food with a spoon to his and Resident 2 opened his to the spoon but would not move his arms. A review of Resident 2's record showed that he needed medication administration. Further review of Resident 2's health assessment dated showed a medical history and diagnoses of unspecified , 's , legally ( ), mixed , , OA ( ) The physical limitations showed legally /bedbound. The status showed AAOX1 (alert, oriented to person) poor verbal. The nursing requirements showed hospice care. Special precautions were and precautions. The activities of daily living (ADL) showed he needed total care with all ADLs, ambulation, bathing, eating, self-care, toileting and transferring. Diet instructions were puree diet, thickener added to	A 053		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 36 liquids. The Resident was bedridden. Needed medication administration, crushed medication, open capsule. Interviewed on at 10:39 AM Staff E stated that she administered medications to Resident 2. A review of resident records revealed that Staff E had signed the MOR for the administration of medications to Resident 2. Interviewed on at 10:42 AM Staff E stated that she was not licensed to administer medications. Staff E further stated that she had not received medication training. Class III	A 053		
A 055 SS=F	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (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	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 37 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 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,	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 38 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 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 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 and interview, the facility failed to ensure that medications were always locked. There were unsecured medications inside a refrigerator, in the bathroom and inside a residents' room. Findings included: Observation on at 10:40 AM revealed	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 39 a bottle of 12% labeled to Resident 3 that was unsecured on top of the bathroom sink (photographic evidence obtained) Further observation on at 10:46 AM revealed 6 boxes of 100 units each of injectable labeled to Resident 3 inside the kitchen refrigerator without a medication box. A box of , , and 0.5 mg/0.2 mg inhalation solution labeled to Resident 2 a was also found unsecured inside the refrigerator (Photographic evidence obtained) Observation on at 10:42 AM revealed cream 2%, cream, , , , 0.5 mg inhalation solution inside a basket on top of a nightstand inside resident # (Photographic evidence obtained) Interviewed on /205 at 10:45 AM Staff E stated that she did not know that medications had to be locked. Class III	A 055		
A 077 SS=L	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 40 has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ˘ ˘ ; 2. If employed on or after . , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator.	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 41 Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 42 satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to have an administrator responsible for the operation of the facility including managing the staff and providing care to the residents. The Administrator had been absent from the country for more than 2 months and left the facility without supervision, only with an unlicensed and unqualified caregiver caring for the residents (Staff E). Findings included: Observations on at 10:35 AM showed that there were 4 residents admitted to the facility,	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 43 one resident was bedbound, legally and unable to communicate, another resident needed daily administration, and 2 other residents had recently been transferred to the hospital due to acute conditions. Further observation showed that Staff E, who was not qualified and was not listed on the facility's staff roster, was working alone at the facility. Interviewed on at 10:40 AM Staff E stated she was the only employee at the facility, and she was responsible for assisting the residents, administering medications, preparing meals and housekeeping chores. Staff E further stated that she did not have First Aid, , , ( ) or medication training, and she could not provide documentation for training, a background screening or a medical clearance statement from a health care provider. Interviewed on at 10:45 AM Staff E stated that she was hired on , and the Administrator was in Brazil. Staff E further stated that she was instructed to contact an unidentified acquaintance of the administrator for her wages and any other facility matters and the Administrator would later relay the information to her. Interviewed on at 10:50 AM when she was asked to contact the Administrator's acquaintance on the telephone Staff E called but the individual would not talk on the telephone. On at 12:20 PM the Administrator called Staff E's telephone and stated that he thought Staff E was qualified but that he would send another, qualified employee to the facility.	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 44 Interviewed on at 1:20 PM a female individual that arrived at the facility stated that she had been sent by the Administrator, but she was not an employee, she was the former owner of the facility which she had sold to the current owner in 2023. The individual further stated that she did not have any documentation, only a CORE card dated 2021. Observation on at 2:20 PM showed that the individual left the facility stating that the Administrator would send somebody else. Interviewed on at 2:25 PM when he was contacted via telephone, the Owner stated that he would send a qualified employee to the facility. Interviewed at 3:15 PM a second female individual that arrived at the facility stated that she had just been hired, and she could stay at the facility for as long as necessary, but she did not have any medication training. Resident 2) Observations on from 11:00 AM through 12:00 PM showed that Resident 2 had severe and and Staff E used a suction machine to extract phlegm from the Resident's and later administered a treatment. Further observation showed Staff E fed Resident 1 pureed food and thickened liquid with a spoon while the Resident remained motionless and with his closed. Interviewed on at 10:45 AM Staff E stated that Resident 2 could not speak, and she administered his medications and treatments. Staff E further stated that a nurse	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 45 came in to see Resident 2 once a week. A review of Resident 2's hospice clinical summary dated through showed "[orders of] medications of 2 liters per minute for as needed. Further reviews showed that staff were trained to provide and how to identify and report signs of and coughing" Interviewed on at 11:55 AM when she was asked how she knew if Resident 2 needed Staff E stated that she only administered him treatments and his medicines. Staff E stated, "I use the pump for the phlegm [ ] and give him the aerosol [ ]. I make sure the bed is lifted. I give him his medicines too" When she was asked about the concentrator and the portable tank that were in Resident 1's room Staff E stated that she did not know what they were and had never used it because she only administered treatments and medications to the Resident. Resident 5) Interviewed on at 10:55 AM Staff E stated that Resident 5 was in the hospital due to a when she left her wheelchair to use the bathroom unassisted. Staff E further stated that she heard Resident 5 calling her and found her on the bathroom floor complaining of in her . Staff E further stated that she did not call the doctor but sent a text to the Resident's daughter who did not respond immediately. Staff E further stated that she called emergency services hours later when a Resident's relative came to the facility and told her to do it.	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: ______ B. WING ______	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 46	A 077		

A review of Resident 5's hospital record dated through showed she was brought to the emergency department via ambulance after she had a at the facility while she was ambulating and transferring from the wheelchair to the toilet and was admitted to the hospital for a right . Further review of the hospital record showed Resident 5 underwent a left , , , surgical procedure.

According to the Cleveland Clinic, a , is a serious injury that requires immediate medical care. A , hemi , is a surgical procedure to treat , when the of the is damaged replacing half of the , with a , .

A review of Resident 5's incomplete (undated) health assessment showed medical history, diagnoses and conditions of , , , history of , , , , status post right , ORIF (open reduction and internal) and right , limitations of ambulation, with behavioral disturbances and required assistance with all activities of daily living (ambulation, bathing, , eating, self-care, toileting, transferring) Special precautions were indicated.

Resident 1)

Interviewed on at 11:00 AM Staff E stated that Resident 1 was in the hospital because she could not defecate for several days. Staff E further stated that she had extracted an from the Resident's body. Staff E further stated that she had not called the doctor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 47 but had notified the Resident's daughter and the Resident was sent to the hospital. A review of Resident 1's hospital discharge records dated showed that she presented at the emergency department via emergency services complaining of severe , on the left side for 3 days, and for 1 day. Further review showed that the Residents' daughter at bedside had stated that the patient lived in a facility, and she was notified that the patient has not had movements for the past 3 or 4 days and was complaining of , . Further review showed that Resident 1 was admitted due to 4 days of , was treated for and was diagnosed with acute , , AKI (acute , injury) , , , , elevated lactic level, of 12th , , and pre- . According to the Cleveland Clinic, "Constant and untreated , can cause fecal impaction. A fecal impaction is the result of constant , when feces are stuck inside the . Fecal impaction is common in the elderly, and it is preventable" Resident 3) A review of Resident 3's record showed doctor's orders for daily monitoring and daily administration of 100 ml 15 units sq for Type II, long term and current use. Further review of Resident 3's medication observation record (MOR) showed, "Administer , once a day at 8:00 AM- 100 units vial, 15 units." A review of Resident 3's medication observation	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 48 record showed no documentation that had been administered on and on . (Photographic evidence obtained) Further review of Resident 3's record showed no documentation that the Resident's level had been monitored or that had been administered on and on . Interviewed on at 10:35 AM Staff E stated that a nurse came to administer to Resident 3 in the afternoon. Staff E stated, "She signs the medication book Sometimes she comes in the morning." Interviewed on at 4:00 PM when asked about Resident 3's missing level readings and administration, the Home Health Agency Nurse stated that she had done it, but she had not documented it on the Resident's medication observation record. When she was asked why she had arrived at 4:00 PM to administer to the Resident the Home Health Nurse stated that sometimes she would come in the mornings, but she had many other patients in distant locations, and she could not always make it at that time and because the Resident went to daycare in the morning. A review of Resident 3's health assessment dated showed medical history and diagnoses of , Type II with long term/current use, , high , , of the , . Physical limitations showed abnormality of gait and mobility, with the use of a walker. status showed alert and oriented to person, time and place. Nursing requirements showed daily administration. Special precautions were	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 49 universal and precautions. The activities of daily living (ADL) showed the Resident needed supervision with bathing, , eating, self-care and toileting and was independent with ambulation and transferring. Needed assistance with pill medications and administration of . Observation on at 10:35 AM showed a physician's order for an test and lavage for wax removal of , cerumen in both , and also an , , card dated at 9:15 AM for an wash for Resident 3 were on top of the visitor's sign-in sheet in the living room. Interviewed on at 10:40 AM when she was asked if the Resident had kept his , , Staff E stated that she had taken care of it. Interviewed on at 3:45 PM when asked if he had the test and the lavage that were ordered by the doctor Resident 3 stated that he had not, that he was still waiting and did not know when it would be done. Observation on at 7:00 PM showed that Resident 2, Resident 1 and Resident 3 were transferred to other facilities when the Administrator and the Owner were not able to provide qualified staff to care for the residents at the facility. Interviewed on at 9:20 AM the Owner stated that he did not know if someone could be at the facility, but he would try to get someone and would call . Interviewed on at 3:45 PM, the Owner	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 077	Continued From page 50 stated that he was out of town, and no one was available to be at the facility. Class 1	A 077		
A 078 SS=L	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 52 background screening or training qualifications to perform assigned duties and responsibilities. Findings included: Observation on at 10:35 AM showed that Staff E was working alone and there were 4 residents admitted to the facility. A review of facility records showed that Staff E was not listed on the facility roster. Further review revealed that Staff E did not have a level 2 background screening. Interviewed on at 10:40 AM Staff E stated that she was the only employee at the facility and that she was hired on as a live-in employee. Staff E further stated that there were no other staff members. Interviewed on at 10:42 AM when asked if she had First Aid and , Training ( ) or medication training Staff E stated that she did not. Staff E stated, "No I don't have that. I don't want to lie. I don't know how to do " Staff E further stated that she could not provide documentation for a negative test report, emergency management, food service, control training or a pre-service orientation. Staff E stated, "I don't know if there are any records here. Maybe the Owner has it." Interviewed on at 10:48 AM when she was asked if she ever had a background screening Staff E stated that she had a police report, but she did not have documentation for it or any other documents on her person. A review of records showed that an employee	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 53 record for Staff E was not found at the facility. Interviewed on at 11:00 AM Staff E stated the Administrator was in Brazil and she could not contact him directly. Staff E further stated that for any eventuality she was instructed to call an acquaintance of the Administrator, and she would relay the information to him. Interviewed on at 10:38 AM Staff E stated that a nurse came to administer to Resident 3 and another nurse visited Resident 2 once a week, but she did not know what hospice care was. Resident 2) Observation on at 10:45 AM showed that Resident 2 was on a hospital bed awake, with his , closed but could not speak. Interviewed on at 11:45 AM Staff E stated, "He [Resident 2] can't speak, he can only say a word or two. A nurse comes to see him once a week" Observations on from 11:00 AM through 11:50 AM showed that Resident 2 had severe and Observation on at 11:30 AM showed that Staff E used the hospital bed's remote control to lift the resident torso to a 45-degree angle and stated, "I lift him up to help him breathe" Further observation showed that Staff E used a suction machine and a probe to suction phlegm from the Resident's and administered a treatment.	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 54 A review of Resident 2's hospice clinical summary dated through showed, "Orders: Teach use. Provide education to caregivers regarding how to identify signs of to report to the care team (, coughing, whizzing) Teach precautions to all caregivers. Medications: ( ) 2 liters per minute inhalation PRN " Interviewed on at 11:55 AM Staff E could not explain the difference between the Resident's orders for when needed for ( ) and the inhalation treatment that was scheduled 3 times per day. Staff E was also not able to determine when the Resident required administration or when to notify the hospice nurse. When she was asked how she knew if the Resident needed Staff E stated that she only gave him treatments. Staff C stated, "I use the pump for the phlegm [ ] and give him the aerosol [ ]. I make sure the bed is lifted and give him his medicines too" When asked when she used the concentrator and the portable tank in the Resident's room Staff E stated "I don't know what that is. I have never used it. I give him aerosol" A review of Resident 2's progress notes dated showed that he had great difficulty breathing, was unable to eat or take his medicines and he was given treatments but was not transferred to the hospital until the following day via emergency service on treatment when the nurse found him unresponsive and unable to move. Further review of Resident 2's progress note	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 55	A 078		

dated showed, "On Saturday, the patient was transferred to [Hospital] According to the staff the day before the patient could not finish his meal due to and she administered the several times on that same day. The next day, , the patient could not take the medications because he would not respond to any stimuli, he could not eat his breakfast either. When the nurse came to administer the injectable , he was not responsive and with the help of the Staff they had to turn him on the bed to administer the injectable medication. Observing the patient's state the Staff called 911 at 10:02 AM. Rescue arrived at 10:11 AM, they evaluated him and noticed that he continued with great difficulty breathing and he was transferred on to [Hospital] at 10:20 AM."

A review of Resident 2's health assessment dated showed a medical history and diagnoses of unspecified , 's , legally , ( ), mixed , OA ( ) The physical limitations showed legally /bedbound. The status showed AAOX1 (alert, oriented to person) poor verbal. The nursing requirements showed hospice care. Special precautions were , and precautions. The activities of daily living (ADL) showed he needed total care with all ADLs, ambulation, bathing, eating, self-care, toileting and transferring. Diet instructions were puree diet, thickener added to liquids. The Resident was bedridden. Needed medication administration, crushed medication, open capsule.

A review of Resident 2's medication observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 56 record showed that Staff E had signed for the Resident's administration of medications (Photographic evidence obtained) According to the Mayo Clinic, " is a condition caused by damage to the . The damage results in and irritation, also called inside the airways. Symptoms include trouble breathing and that brings up . People with have damage to their that makes it harder to breathe. is the most common symptom of " Resident 5) Interviewed on at 10:55 AM Staff E stated that Resident 5 was in the hospital after she had a on in the afternoon while going to the toilet alone. Staff E also stated that she called emergency services hours later when a family member arrived at the facility and told her to do it. Interviewed on at 10:55 AM Staff E stated, "[Resident 5] is in the hospital. She on Saturday in the afternoon. I was in the kitchen when I heard [Resident 5] calling me and I found her on the bathroom floor; her wheelchair was in the hallway. She was complaining of in her . I think that she dropped her soap and tried to pick it up. I put her in the wheelchair, took her to her room and put her to bed. It was hard because she was heavy. I sent a text to her daughter, but she did not answer right away. Later when I talked to her daughter, she told me to call her brother-in-law if [Resident 5] had during the night. I called her daughter to tell her that [Resident 5] was in , and her brother-in-law came in at around 8:00 PM. He	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 57 told me to call 911. I called 911, they came and took her to the [Hospital]. She is still there. [Resident 5] has been in the hospital before, at least 3 times. One time she passed out like she was . I called 911 and her daughter also. They took her to the hospital, and her daughter said that she needed ." A review of Resident 5's hospital record dated through showed that she arrived at the Emergency Department via ambulance after a mechanical at her ALF ambulating when trying to transfer from the wheelchair to the toilet. The patient stated that she went to use the restroom and . Patient was admitted to the hospital for right , and underwent left . According to the Cleveland Clinic, a is a serious injury that requires immediate medical care. A hemi is a surgical procedure to treat when the of the is damaged replacing half of the with a " A review of Resident 5's incomplete health assessment (missing page, date unknown) showed medical history and diagnoses of , history of , , status post right , ORIF (open reduction and internal) right . The physical limitations showed ambulatory limitations. The status showed with behavioral disturbances. The nursing requirements showed the Resident needed assistance with ambulation, bathing, , self-care, toileting and transferring, supervision with eating. The Resident had special	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 58 precautions and , precautions. Resident 1) Interviewed on at 11:00 AM Staff E stated that Resident 1 was in the hospital because she could not defecate for several days. Staff E further stated that she had extracted an , from the Resident's body, and she did not call the doctor but notified the Resident's daughter and the Resident was sent to the hospital. A review of Resident 1's hospital discharge records dated showed that she presented at the emergency department via emergency services complaining of severe , on the left side for 3 days, and _ for 1 day. Further review showed that the Residents' daughter at bedside had stated that the patient lived in a facility, and she was notified that the patient had not had a movement for the past 3 or 4 days and was complaining of , . Further review showed that Resident 1 was admitted due to 4 days of , , was treated for and diagnosed with acute , , , AKI (acute , injury) , , , elevated lactic level, of 12th , , , and pre- . According to the Cleveland Clinic, "Constant and untreated , can cause fecal impaction. A fecal impaction is the result of constant , when feces are stuck inside the . Fecal impaction is common in the elderly, and it is preventable" Resident 3)	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 59 Interviewed on at 10:35 AM Staff E stated that a nurse came to administer injectable to Resident 3 in the afternoon. Staff E stated, "She signs the medication book. Sometimes she comes in the morning." A review of Resident 3's medication observation record showed no documentation that had been administered on and on . (Photographic evidence obtained) A review of Resident 3's record showed doctor's orders for daily monitoring and administration of 100 ml 15 units sq daily for Type II, long term and current use. Further review of Resident 3's medication observation record (MOR) showed, "Administer , once a day at 8:00 AM- 100 units vial, 15 units." Further review of Resident 3's record showed no documentation that the Resident's level had been monitored or that had been administered on and on . Interviewed on at 4:00 PM when asked about the missing documentation of Resident 3' level readings and administration, the Home Health Agency Nurse stated that she had done it, but she had not documented the Resident's medication observation record. When she was asked why she had arrived at 4:00 PM to administer to the Resident the Home Health Nurse stated that sometimes she would come in the mornings, but she had many other patients in distant locations, and she could not always make it at that time and because the Resident went to daycare in the morning.	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 60 A review of Resident 3's health assessment dated showed medical history and diagnoses of Type II with long term/current use, high of the . Physical limitations showed abnormality of gait and mobility, with the use of a walker. status showed alert and oriented to person, time and place. Nursing requirements showed daily administration. Special precautions were universal and precautions. The activities of daily living (ADL) showed the Resident needed supervision with bathing, eating, self-care and toileting and was independent with ambulation and transferring. Needed assistance with pill medications and administration of . Observation on at 10:35 AM showed a physician's order for an and lavage for wax removal of cerumen in both and an card dated at 9:15 AM for an wash for Resident 3 were on top of the visitor's sign-in sheet in the living room. Interviewed on at 10:40 AM when she was asked if the Resident had kept his Staff E stated that she had taken care of it. Interviewed on at 3:45 PM when asked if he had the test and the lavage that were ordered by the doctor Resident 3 stated that he had not, he was still waiting, and he did not know when it would be done. Class 1	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 61	A 079		
A 079 SS=L	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

(3) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 62 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 63 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 64 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, interview and record review the facility failed to have a staff member present who had completed courses on First Aid and , , , . The facility also failed to have a designated staff member in charge of the facility present during the absence of the Administrator. The Administrator had been absent and out of the country for over 2 months and there were no qualified staff or designated staff in charge while there were 4 residents admitted to the facility.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 65 Findings included: Observations on from 10:35 AM through 7 PM showed that there were 3 residents present at the facility, Resident 2 was bedbound, legally , unable to communicate, needed medication administration and total care with ADLs (activities of daily living), Resident 3 needed daily administration and Resident 1 had been discharged from the hospital and needed assistance with all ADLs. Further observation showed that Staff E, who was not qualified and was not listed on the facility's staff roster, was the only caregiver at the facility. Interviewed on at 10:40 AM Staff E stated she was the only employee at the facility, she did not know how to perform First Aid, , , ( ), did not have documentation for training and she was responsible for assisting the residents, administering medications, preparing meals and the housekeeping chores. Staff E further stated that she did not know where all the facility and resident records were. Interviewed on at 10:45 AM Staff E stated that she was hired on . and the Administrator was in Brazil. Staff E further stated that she was instructed to contact an unidentified acquaintance of the administrator for her wages and other facility matters and the Administrator would later relay the information to her. Resident 2) Observation on at 10:45 AM showed that Resident 2 was on a hospital bed awake, with his , closed but could not speak.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 66 Interviewed on at 11:45 AM Staff E stated, "He [Resident 2] can't speak, he can only say a word or two. A nurse comes to see him once a week" Observations on from 11:00 AM through 11:50 AM showed that Resident 2 had severe and . Further observation showed that Staff E used a suction machine and a probe to suction phlegm from the Resident's . A review of Resident 2's hospice clinical summary dated through showed, "Orders: Teach use. Provide education to caregivers regarding how to identify signs of to report to the care team (, coughing, whizzing) Teach , precautions to all caregivers. , Medications: ( ) 2 liters per minute inhalation PRN " Interviewed on at 11:55 AM Staff E could not explain the difference between the Resident's orders for when needed for ( ) and the inhalation treatments with the that were scheduled 3 times per day, and she was not able to determine when the Resident's required administration or when to notify the hospice nurse. When she was asked how she knew if the Resident needed Staff E stated that she only gave him treatments. Staff E stated, "I use the pump for the phlegm [extract] and give him the aerosol [ ]. I make sure the bed is lifted. I give him his medicines too" When asked when she used the concentrator and a portable tank in the Resident's room Staff E stated "I don't know what	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 67	A 079		

that is. I have never used it. I give him aerosol"
A review of Resident 2's progress notes dated showed that he had great difficulty breathing, was unable to eat or take his medicines and he was given treatments but was not transferred to the hospital until the following day via emergency service on . . treatment when the nurse found him unresponsive and unable to move.
Further review of Resident 2's progress note dated showed, "On Saturday, the patient was transferred to [Hospital] According to the staff the day before the patient could not finish his meal due to and she administered the several times on that same day. The next day, , the patient could not take the medications because he would not respond to any stimuli, he could not eat his breakfast either. When the nurse came to administer the injectable , he was not responsive and with the help of the Staff they had to turn him on the bed to administer the injectable medication. Observing the patient's state the Staff called 911 at 10:02 AM. Rescue arrived at 10:11 AM, they evaluated him and noticed that he continued with great difficulty breathing and he was transferred on to [Hospital] at 10:20 AM."

A review of Resident 2's health assessment dated showed a medical history and diagnoses of unspecified , , 's , legally , (,), mixed , , , OA ( )
The physical limitations showed legally /bedbound. The status showed AAOX1 (alert, oriented to person) poor verbal. The nursing requirements showed hospice care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 68 Special precautions were , and precautions. The activities of daily living (ADL) showed he needed total care with all ADLs, ambulation, bathing, , eating, self-care, toileting and transferring. Diet instructions were puree diet, thickener added to liquids. The Resident was bedridden. Needed medication administration, crushed medication, open capsule. A review of Resident 2's medication observation record showed that Staff E had signed for the Resident's administration of medications (Photographic evidence obtained) According to the Mayo Clinic, " is a condition caused by damage to the . The damage results in and irritation, also called inside the airways. Symptoms include trouble breathing and that brings up . People with have damage to their that makes it harder to breathe. is the most common symptom of " Resident 5) Interviewed on at 10:55 AM Staff E stated that Resident 5 was in the hospital after she had a on while going to the toilet alone. Staff E stated that she called emergency services hours later when a family member arrived at the facility and told her to do it. Interviewed on at 10:55 AM Staff E stated, "[Resident 5] is in the hospital. She on Saturday in the afternoon. I was in the kitchen when I heard [Resident 5] calling me and I found her on the bathroom floor; her wheelchair was in the hallway. She was complaining of , in her . I think that she dropped her soap and tried to	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 69	A 079		

pick it up. I put her in the wheelchair, took her to her room and put her to bed. It was hard because she was heavy. I sent a text to her daughter, but she did not answer right away. Later when I talked to her daughter, she told me to call her brother-in-law if [Resident 5] had during the night. I called her daughter to tell her that [Resident 5] was in , and her brother-in-law came in at around 8:00 PM. He told me to call 911. I called 911, they came and took her to the [Hospital]. She is still there. [Resident 5] has been in the hospital before, at least 3 times. One time she passed out like she was . I called 911 and her daughter also. They took her to the hospital, and her daughter said that she needed ."

A review of Resident 5's hospital record dated through showed that she arrived at the Emergency Department via ambulance after a mechanical at her ALF ambulating when trying to transfer from the wheelchair to the toilet. The patient stated that she went to use the restroom and . The patient was admitted to the hospital for a right , and underwent left , .

According to the Cleveland Clinic, a is a serious injury that requires immediate medical care. A hemi , is a surgical procedure to treat when the of the is damaged replacing half of the with a "

A review of Resident 5's incomplete health assessment (missing page, date unknown) showed medical history and diagnoses of history of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 70 , , , , , status post right , ORIF (open reduction and internal) right , . The physical limitations showed ambulatory limitations. The status showed , with behavioral disturbances. The nursing requirements showed the Resident needed assistance with ambulation, bathing, , self-care, toileting and transferring, supervision with eating. The Resident had special precautions and , precautions. Resident 1) Interviewed on at 11:00 AM Staff E stated that Resident 1 was in the hospital because she could not defecate for several days. Staff E further stated that she had extracted an , from the Resident's body, and she had not called the doctor, but she notified the Resident's daughter, and the Resident was sent to the hospital. A review of Resident 1's hospital discharge records dated showed that she presented at the emergency department via emergency services complaining of severe , on the left side for 3 days, and , for 1 day. Further review showed that the Residents' daughter at bedside had stated that the patient lived in a facility, and she was notified that the patient had not had a movement for the past 3 or 4 days and was complaining of , . Further review showed that Resident 1 was admitted due to 4 days of , , was treated for and diagnosed with acute , , AKI (acute , injury) , , , elevated lactic level, of 12th , , and pre- .	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 71 According to the Cleveland Clinic, "Constant and untreated , can cause fecal impaction. A fecal impaction is the result of constant , when feces are stuck inside the . Fecal impaction is common in the elderly, and it is preventable" Resident 3) Interviewed on at 10:35 AM Staff E stated that a nurse came to administer injectable to Resident 3 in the afternoon. Staff E stated, "She signs the medication book. Sometimes she comes in the morning." A review of Resident 3's medication observation record showed no documentation that had been administered on and on . (Photographic evidence obtained) A review of Resident 3's record showed doctor's orders for daily monitoring and administration of 100 ml 15 units sq daily for Type II, long term and current use. Further review of Resident 3's medication observation record (MOR) showed, "Administer , once a day at 8:00 AM- 100 units vial, 15 units." Further review of Resident 3's record showed no documentation that the Resident's level had been monitored or that had been administered on and on . Interviewed on at 4:00 PM when asked about the missing documentation of Resident 3' level readings and administration, the Home Health Agency Nurse stated that she had done it, but she had not documented it on the Resident's medication observation record. When she was asked why	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 72	A 079		

she had arrived at 4:00 PM to administer to the Resident the Home Health Nurse stated that sometimes she would come in the mornings, but she had many other patients in distant locations, and she could not always make it at that time and because the Resident went to daycare in the morning.

A review of Resident 3's health assessment dated showed medical history and diagnoses of , Type II with long term/current use, , high , , , of the , . Physical limitations showed abnormality of gait and mobility, with the use of a walker. status showed alert and oriented to person, time and place. Nursing requirements showed daily administration. Special precautions were universal and precautions. The activities of daily living (ADL) showed the Resident needed supervision with bathing, , eating, self-care and toileting and was independent with ambulation and transferring. Needed assistance with pill medications and administration of .

Observation on at 10:35 AM showed a physician's order for an and lavage for wax removal of , cerumen in both , and an , , card dated at 9:15 AM for an wash for Resident 3 were on top of the visitor's sign-in sheet in the living room.

Interviewed on at 10:40 AM when she was asked if the Resident had kept his , , Staff E stated that she had taken care of it.

Interviewed on at 3:45 PM when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 73 asked if he had done the test and the lavage that were ordered by the doctor Resident 3 stated that he had not, that he was still waiting, and he did not know when it would be done. Class 1	A 079		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 160	Continued From page 74 intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 160	Continued From page 75 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate admission and discharge log. The location to which residents were discharged was not documented. Findings included: A review of the facility's admission and discharge log showed that Resident 4 was discharged on	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 160	Continued From page 76 and the reason for discharge showed " " The location to which the Resident was discharged was left blank. Interviewed on at 10:46 AM Staff E stated that Resident 4 , , before she started working at the facility. Class III	A 160		
{A 162} SS=F	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 practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 77 (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ␣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ␣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ␣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, 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.	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 78 (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this 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.	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 79 (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate resident records for 2 out of 4 sampled residents (Residents 5 and 1) Resident 5's health assessment 1823 and demographic data sheet were incomplete. Resident 1's health assessment 1823 and demographic data sheet were incomplete. Findings included: A review of Resident 5's health assessment date unknown, revealed that the last page which would document the Resident's medication requirements, date and the health care provider's name, telephone number and signature was missing. Further review of Resident 5's record showed that the name section on the Resident's demographic information sheet was left blank. A review of Resident's health assessment 1823 dated revealed that the nursing requirements section was left blank. Further review of Resident 1's record showed that the date of birth section on the Resident's demographic information sheet was left blank. Interviewed on at 11:10 AM Staff E stated that she did not know anything about the resident records.	{A 162}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969674	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH TOWER ALF LLC	432 N.W. 15 ST HOMESTEAD, FL 33030

(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 80 Class III	{A 162}		