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
	AL11965409	A. BUILDING: _____ B. WING _____	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY CRIST HOME CARE ALF, INC	1706 SW 136 PLACE MIAMI, FL 33175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey and generator monitoring was conducted at Cary Crist Home Care ALF, Inc on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain a written record, updated as needed, of any significant changes or illnesses for one out of five (Resident #1) sampled residents. The facility failed to maintain accurate records of any significant changes or illnesses for one out of five (Resident #3) sampled residents. Findings included: 1) A review of Resident #1's record showed he was admitted to the facility on and had a diagnosis of 's without dyskinesia, with fluctuations, primary generalized	A 025		

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A 025	Continued From page 2 (osteo) , other , , , age-related decline, unspecified , mild, and . The health assessment dated indicated the resident needed medication administration. A review of Resident #1's progress notes showed that she was transferred to the hospital with and , , on . The record did not document that her primary physician and family members were notified that the resident was transferred to the hospital. On at 11:10 AM, the Administrator confirmed that Resident #1 progress notes were incomplete. 2) A review of Resident #3's record showed she was admitted to the facility on and had a diagnosis of , , and , . The health assessment dated showed the resident was independent with transferring, needed supervision with ambulation, eating, and toileting, and needed assistance with bathing, , and self-care. A review of Resident #3's progress notes showed the resident finished her lunch and went to her room to brush her on . She hurt her with her bed. She was complaining of , . Her primary physician was informed and ordered an of her . Her son was informed. A review of the online Adverse Incident Reporting System database showed that Resident #3 was found on the floor of her bedroom on at 12:32 pm on Sunday. "She stated , in her . Her son was informed and the primary	A 025		

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A 025	Continued From page 3 doctor as well. She was able to stand and walk. The resident was given the option to go to the hospital and refused, her son came to see her. She was observed closely but she was oriented and able to walk. A follow-up with the physician will take place today. The resident is alert and oriented there were no signs of . . . . or other type of injury." On at 10:15 AM, Resident #3 stated that she in her room and hurt her . She stated that an , was done on her and she was waiting for the results. She added that the physician ordered a walker for her. On at 11:10 AM, the Administrator stated that she filed the adverse incident report for Resident #3 but she canceled it because she did not know if the resident or she was looking for something under her bed. Class II	A 025		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case	A 162		

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A 162	Continued From page 4 of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ◡ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. This subsection does not apply to 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.	A 162		

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A 162	Continued From page 5 (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (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	A 162		

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A 162	Continued From page 6 who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have an accurate health assessment for one out of five (Resident #1) sampled residents. Findings included: A review of Resident #1's record showed he was admitted to the facility on and had a diagnosis 's without dyskinesia, with fluctuations, primary generalized (osteo) , other , , , age-related decline, unspecified , mild, with . The health assessment dated indicated the resident needed medication administration. A review of Resident #1's progress notes dated showed that "She is no longer needing medication administration as she is not and is able to drink her own medications	A 162		

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A 162	Continued From page 7 as noted by hospice." On at 11:10 AM, the Administrator stated that the resident's condition changed and she talked to the resident's doctors to get a new health assessment. Class III	A 162		