

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 An abbreviated survey with a generator monitoring was conducted at Loreto Homes Inc. on . The provider had deficiencies at the time of the survey.	A 000			
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property"	A 004			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 004	Continued From page 1 means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of an updated annual fire safety inspection. Findings: A review of the facility inspections found no documentation of an updated annual fire safety inspection. Interviewed on _____ at 3:10 PM the Administrator stated that the fire department stated that there was a delay.	A 004		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 004	Continued From page 2 Class III	A 004		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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)
A 025	Continued From page 3 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 record review and interview, the facility failed to ensure the Administrator who served as representative payee for Residents #2 and #3, who received Optional State Supplemental income (), maintained a surety bond in an amount equal to twice the average monthly aggregate income or personal funds which were received. Findings: 1) A review of Resident #2's check in the amount of \$184.40 dated showed the name of the resident and showed that the funds arrived in care of [the facility] and written on the	A 025	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 025	Continued From page 4 of the check "deposit only." Photographic evidence obtained. A review of Resident #2's health assessment with a completion date of _____ showed a _____ or behavioral status as _____, _____ ability appropriate with medication. A review of Resident #3's account log showed her check of \$184.40 was deposited in the facility's account and she signed and received only \$160.00. On _____, the account log showed her check of \$140.00 was deposited in the facility's account and she signed and received \$140.00. However, a balance of \$140.00 remained in the facility's account. A review of Resident #3's health assessment dated _____ showed a _____ or behavioral status of _____, _____ ability due to _____. A review of the facility records showed no surety bound in an amount equal to twice the average monthly aggregate income or personal funds which were received by the facility. Interviewed on _____ at 3:10 PM the Administrator stated that it was a mistake and that any remaining money went towards their rent (Residents #2 and #3). The Administrator stated further that she did not have a surety bond. Class III	A 025			
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing:	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025																						
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 5 1. Facilities must maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents, Day Care Participants, and Respite Care Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td>6-25</td> <td>212</td> </tr> <tr> <td>26-35</td> <td>253</td> </tr> <tr> <td>36-45</td> <td>294</td> </tr> <tr> <td>46-55</td> <td>335</td> </tr> <tr> <td>56-65</td> <td>375</td> </tr> <tr> <td>66-75</td> <td>416</td> </tr> <tr> <td>76-85</td> <td>457</td> </tr> <tr> <td>86-95</td> <td>498</td> </tr> <tr> <td></td> <td>539</td> </tr> </table> For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there 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	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168	6-25	212	26-35	253	36-45	294	46-55	335	56-65	375	66-75	416	76-85	457	86-95	498		539	A 079		
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																									
0-5	168																									
6-25	212																									
26-35	253																									
36-45	294																									
46-55	335																									
56-65	375																									
66-75	416																									
76-85	457																									
86-95	498																									
	539																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 6 () 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 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	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 7 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 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	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 8 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, record review and interview, the facility also failed to provide a staffing pattern that reflected the minimum required 252 Hours/Week for a census of six (6) residents. Findings: Observation on _____ at 9:05 AM found six residents (#1, #2, #3, #4, #5, #6) in the facility. A review of the Admissions and Discharge log listed a total of six residents. Interviewed on _____ at 9:05 AM when asked how many residents were in the house, the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 9 Administrator stated, "Six." A review of the staffing pattern for the week of _____ through _____ showed only 192 weekly hours for a census of six residents. Photographic evidence obtained. Interviewed on _____ at 3:10 PM the Administrator stated that they live there. Class III	A 079			
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.frules.org/Gateway/reference.asp?No=Ref-04003 , and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025	
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 093	Continued From page 10 resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 093	Continued From page 11 necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by:	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 093	Continued From page 12 Based on observation, record review and interview, the facility failed to follow the posted menu for six (#1, #2, #3, #4, #5, #6) out of six sampled residents prescribed and approved by a registered dietitian. The facility failed to make a noted substitution on or before meal was served. Findings: A review of the posted menu dated showed sausage, white rice, soup, mixed salad with carrots, fruits, and milk. The menu noted milk for Observation on at 11:45 AM Residents #1, #2, and #4 served sausage, white rice, soup (lentil), mixed salad with carrots, fruits (bananas/apple), and a 12 oz. canned soda each. However, milk was not served. Observation at 12:15 PM Residents #3, #5, and #6 were served sausage, white rice, soup (lentil), mixed salad with carrots, fruits (bananas/apple), and a 12 oz. canned soda each. However, milk was not served. A review of Resident #3's health assessment with a completion date of showed a diagnosis of Type II Interviewed on at 3:10 PM the Administrator acknowledged that the menu was not followed. Class III	A 093			
A 123 SS=D	429.27() FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds	A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 123	Continued From page 13 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of \$500 and funds of the resident not in excess of \$500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of \$500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident. (5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand,	A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 123	Continued From page 14 require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies. 59A-36.013 (2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or due a resident, including personal funds, must be held as trust funds and expended only for the resident's account. Resident funds or property may be held in one bank account if a separate written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility Administrator failed to provide for the safekeeping in the facility of personal effects not in the excess and funds of the resident not in the excess of \$500 cash and shall keep complete and accurate records of all such funds and personal effects	A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 123	Continued From page 15 received for Residents #2, and #3. The facility failed to document and provide receipts of items purchased for Residents #2 and #3. Findings: 1) A record review Resident #2's account log showed on _____, _____ and _____ resident signed and received a total of \$480.00. Photographic evidence obtained. Interviewed on _____ at 2:56 PM Resident #2 stated that the money the Administrator gives her buys cigarettes and clothes. Interviewed on _____ at 3:10 PM when asked what happened with the Resident #2's money, the Administrator stated that the resident buys cigarettes. When asked where the documentation and receipts were, the Administrator stated that she did not have any records. 2) A review of Resident #3's account log on _____ and _____ showed the resident signed and received \$300.00. Photographic evidence obtained. Interviewed on _____ at 3:10 PM the Administrator stated that she did not have any receipts. The Administrator stated further that Resident #3 likes the expensive cigarettes and that she buys the cigarette at the [casino] where she does not pay any taxes. The Administrator concluded that she did not have any receipts.	A 123			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 123	Continued From page 16 Interviewed on _____ at 2:50 PM Resident #3 stated that she never gets the money. Resident #3 stated further that she signs for it and the owner goes and buys the cigarettes for her. Class III	A 123			
A 125 SS=D	429.27(2) FS; 59A-36.013(3) FAC Fiscal - Surety Bonds 429.27 (2) A facility, or an owner, administrator, employee, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. An owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the consent of the resident. Any facility whose owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility as principal and a licensed surety company. The bond shall be conditioned upon	A 125			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 125	Continued From page 17 the faithful compliance of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection. 59A-36.013 (3) SURETY BONDS. Pursuant to the requirements of section 429.27(2), F.S.: (a) For entities that own more than one facility in the state, one surety bond may be purchased to cover the needs of all residents served by the entities. (b) The following additional bonding requirements apply to facilities serving residents receiving : 1. If serving as representative payee for a resident receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or social security , income plus the payments, including the personal needs allowance. 2. If holding a power of attorney for a resident	A 125			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 125	Continued From page 18 receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or social security , income; the payments, including the personal allowance; plus the value of any property belonging to a resident held at the facility. (c) Upon the annual issuance of a new bond or continuation bond, the facility must file a copy of the bond with the Agency Central Office. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Administrator who serves as representative payee for Residents #2 and #3 recipients of , , file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds which are received by the facility. Findings: 1) A review of Resident #2's check in the amount of \$184.40 dated showed the name of the resident and in care of [the facility] and written on the of the check "deposit only." Photographic evidence obtained. A review of Resident #2's health assessment with a completion date of showed a ~ or behavioral status as ~ ability appropriate with medication. A record review of Resident #3's account log showed her check of \$184.40 was deposited in the facility's account and she signed	A 125			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 125	Continued From page 19 and received only \$160.00. On _____, the account log showed her check of \$140.00 was deposited in the facility's account and she signed and received \$140.00. However, a balance of \$140.00 remained in the facility's account. A review of Resident #3's health assessment with a completion date of _____ showed a _____ or behavioral status of _____ _____ ability due to _____, _____, _____. A review of the facility records showed no surety bound in an amount equal to twice the average monthly aggregate income or personal funds which are received by the facility. Interviewed on _____ at 3:10 PM the Administrator stated that it was a mistake and that any remaining money goes towards their rent (Residents #2 and #3). The Administrator stated further that she does not have a surety bond. Class III	A 125			
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 152	Continued From page 20 belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe and decent living environment, free of hazards for six (#1, #2, #3, #4, #5, #6) out of six sampled residents. Findings: Observation on _____ at 9:11 AM Resident #1 had access to a knife left on the kitchen counter while seated approximately three yards away at the dining tables. Photographic evidence obtained of the knife on the counter.	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 152	Continued From page 21 Observation on _____ at 9:17 AM found a soiled _____ on floor apparently used by dogs. Photographic evidence obtained. Observation on _____ at 9:49 AM knife remained on kitchen counter accessible to residents. A review of the Admissions and Discharge log showed Residents #1, #2, #3, #4, #5, and #6 were all mental health residents. Observation on _____ at 2:51 PM knife remained on kitchen counter. Interviewed on _____ at 3:10 AM Staff B (Caregiver) stated that the kitchen was locked and that the residents don't have access to the kitchen. Interviewed on _____ the Administrator stated that they (employees) were right there. Class III	A 152		
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	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 22 other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration 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,	A 162			

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 24 Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to update Resident #1 health assessment due to a significant change in condition. Findings: Observation on _____ at 2:00 PM transportation arrived to pick up Resident #1 to take her to receive _____. A review of Resident #1's health assessment with a completion date of _____ showed no diagnosis of _____ or _____. Interviewed on _____ at 12:57 PM the _____	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967348	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER LORETO HOMES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 770 NW 9 COURT 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 25 Administrator stated that Resident #1 received three times per week. The Administrator stated further that Resident #1 started on . When asked why the health assessment was not updated, the Administrator did not provide an answer. A review of Resident #1's progress notes documented resident receiving on . Class III	A 162			