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
	AL11966548	A. BUILDING: _____ B. WING _____	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVENLY HOME CARE OF FLORIDA, INC	17321 SW 109 AVENUE MIAMI, FL 33157

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (2025002068 and 2025001387) was conducted at Heavenly Home Care of Florida on . Deficiencies were identified at the time of the investigation.	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		

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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 interview and record review, the facility failed to have an updated and approved Fire Annual Operating Permit for review. Findings Included: A review of the permits on the bulletin board showed the Fire Annual Operating Permit had an expiration date of . During the exit interview on at 9:20 am the Administrator stated the fire department had come out to complete the inspection, but she	A 004		

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A 004	Continued From page 2 wasn't present. Class III	A 004		
A 010 SS=D	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, and the resident is under the care of a physician who agrees that the physical needs of the	A 010		

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A 010	Continued From page 3 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. (3) A physician, physician assistant, or advanced	A 010		

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A 010	Continued From page 4 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, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 5 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 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by:	A 010		

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A 010	Continued From page 6 Based interview and record review the facility failed to ensure the appropriateness of continued residency for one out of five sampled residents (Resident #1) who had a history of leaving the facility without the Administrator knowing Resident's 1 whereabouts. Findings Included: A review of the compliant database records showed Resident #1 left the facility on and the staff were unable to locate her. Resident #1 returned to the facility on . The resident had not been medically assessed as an elopement risk. A review of the compliant database further revealed that on Resident 1 left the facility without notifying staff and did not return until . A review of the facility progress notes showed for the month of , showed, '[Resident #1's] behavior changes was noted as very rude and demanding. Also, the monthly progress note showed Resident #1 was "cursing and telling lies and arguing with her friends. She is being moody and left on at about 7 pm." A review of the facility progress notes showed for the month of Resident #1 behavior changes was noted as very rude. Further review of the progress notes showed Resident #1 was getting angry when she was asked to shower. Resident #1 was sent to the hospital for 'acting up and being .' A review of the facility progress notes showed for the month of Resident #1's behavior changes were noted as 'very rude'. The	A 010		

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A 010	Continued From page 7 progress notes also showed Resident was sent to the hospital for 'being rude, yelling, and screaming. Resident 1 claimed that she was ' and that there were snakes in her ' ' A review of the facility progress notes showed for the month of 'Resident behavior changes were noted as very rude'. Also, the progress notes showed Resident #1 was 'spitting on the floor and slamming doors.' A review of Resident's 1 health assessment showed a diagnosis of Schizotypal . Resident #1 was not listed an elopement risk. Resident #1 needed assistance with ambulation, self-care grooming, transferring. Resident #1 needed supervision with bathing and eating. In an interview on at 7:45 am, the Administrator stated "I've been dealing with [Resident #1] for about a year, trying to manage her behavior problems. [Resident #1] has been at the facility for 15 years." Also, the Administrator stated Resident #1 had been leaving the facility without letting her know. The Administrator further stated, "it's been rough another agency had come out and it's just been one thing after another with [Resident #1]." Class III	A 010		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement.	A 032		

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A 032	Continued From page 8 All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must	A 032		

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A 032	Continued From page 9 provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to follow its own policies and procedures to ensure that one out of the five sampled residents with a history of elopement (Resident #1) had a form of identification on her person that included her name the facility's address, and telephone number. Findings Included: A review of the compliant database records showed Resident #1 left the facility on and the staff were unable to locate her. Resident #1 returned to the facility on . A review of the compliant database further revealed that on Resident 1 left the facility without notifying staff and did not return until	A 032		

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A 032	Continued From page 10 Interviewed on at 7:45 am the Administrator stated Resident #1 did not want to tell her where she was going and had Resident #1 consent to wearing an air tag, but Resident #1 had taken it off and throwed it away. The Administrator also stated she had been dealing with Resident #1 behavior problems and her leaving the facility for a year. A review of the facility's elopement procedures showed that the facility will ensure that residents at risk of elopement have a photo identification with the resident's name, facility name, address, and telephone number. Class III	A 032		
A 036 SS=E	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a	A 036		

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A 036	Continued From page 11 shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to reduce the risk of the transmission of for four out of the five sampled residents (#2, #3, #4, and #5). The administrator failed to clean and used the same gloves while assisting the four residents with medications. Findings Included: Observation on at 6:53 am showed the Administrator popped several medications from the pack into her gloved and placed the medication into a red cup and handed it to Resident #2. Observation on at 6:55 am showed the Administrator came over to Resident #3 without changing her gloves and or using hygiene, grabbed the pack and started popping medication into her gloved , and placed the medication into a red cup and handed it to Resident #3. Observation on at 6:57 am showed the Administrator went over to assist Resident #4 with the same unchanged gloves, popped medication from the pack into her gloved and placed the medication into a red cup and handed it to Resident #4.	A 036		

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A 036	Continued From page 12 Observation on at 6:59 am showed the Administrator without exchanging her gloves or removing them to sanitize went on with medication pass, popped medication from a pack into her gloved and placed the medication into a red cup and handed it to Resident #5. During the exit interview on at 9:20 the Administrator stated she was unaware of the need to change gloves and have hygiene when assisting the residents with their medication. Class III	A 036		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone	A 054		

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A 054	Continued From page 13 number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medication records were accurate for one of five sampled residents (Resident #4). Findings: On at 6:14 am, observation in # on an uncovered dish on the dresser nearest the door, revealed two white pills (photographic evidence obtained). Interviewed on at 6:15 am, Resident #4 stated regarding the pills, "It's my medicine." Interviewed on at 6:17 am, the Administrator stated, that's not [Resident #4's] medication. Observation on at 6:18 am revealed that the pills were white and round, with the numbers 90/8 inscribed. A review of data from 'Drugsite Limited' showed that the pills were . A review of the Medication Observation Record	A 054		

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	AL11966548	A. BUILDING: _____ B. WING _____	03/11/2025

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A 054	Continued From page 14 for Resident #4 revealed that the resident was prescribed , 100 mg, one tablet at 6:00 pm daily. Further review showed that the medication was signed, indicating that the resident had taken the medications for all days in , to date. A review of Resident #4's health assessment dated revealed that the resident needed assistance with self -administration of medications. Further review revealed that the resident was diagnosed with , , , type, and . Class III	A 054		
A 055 SS=H	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 facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented	A 055		

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A 055	Continued From page 15 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, 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	A 055		

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A 055	Continued From page 16 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, interview, and record review, the facility failed to ensure that medications were locked. Findings: On at 6:14 am, observation in # on an uncovered dish on the dresser nearest the door, revealed two white pills (photographic evidence obtained). Further observation revealed two residents (Residents #4 and 5) occupying the room.	A 055		

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A 055	Continued From page 17 Interviewed on at 6:15 am, Resident #4 stated regarding the pills, "It's my medicine." Interviewed on at 6:17 am, the Administrator stated, that's not [Resident #4's] medication. Observation on at 6:18 am revealed that the pills were white and round, with the numbers 90/8 inscribed. A review of data from 'Drugsite Limited' showed that the pills were . A review of the Medication Observation Record for Resident #4 revealed that the resident was prescribed , 100 mg, one tablet at 6:00 pm daily. Further review showed that the medication was signed, indicating that the resident had taken the medications for all days in , to date. A review of Resident #4's health assessment dated revealed that the resident needed assistance with self -administration of medications. Further review revealed that the resident was diagnosed with , , , , type, and . A review of the National Library of Medicine database showed, " is used to treat , , is in a class of medications called modulators. It works by increasing the amount of , a natural substance in the that helps maintain mental balance. Do not stop taking without talking to your doctor. If you suddenly stop taking , you may experience withdrawal symptoms such as ; ; ;	A 055		

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A 055	Continued From page 18 ; , ; agitation; difficulty falling asleep or staying asleep; extreme tiredness; ; , , , or tingling in the or ; frenzied or abnormally excited ; ringing in the ; or sweating. " A review of Resident #5's health assessment dated showed diagnoses of , , , type, , , , and , type one. Resident #5 needed assistance with self-administration of medications. Class II	A 055		
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.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the	A 093		

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A 093	Continued From page 19 residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of 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	A 093		

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A 093	Continued From page 20 choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˬ 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	A 093		

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A 093	Continued From page 21 obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the regular/therapeutic dietary food menu and did not document the substitute meal for 5 out of 5 sampled residents. Findings Included: Observation on at approximately 7:28 am showed five residents were served scrambled eggs, toasted bread, margarine, Vienna sausages, and blue berries for breakfast. A review of the facility records showed a menu dated , 2025; Wednesday Breakfast menu Assorted Juices, Waffles, Margarine, Syrup, DB: Sugar-free syrup, and Milk. During the exit interview on at 9:20 am the Administrator stated, "I followed the Tuesday menu with everything going on and getting up at six in the morning it was an honest mistake." Class III	A 093		
A 152 SS=E	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.;	A 152		

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A 152	Continued From page 22 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 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 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 provide a safe living environment free of hazards. Additionally, the facility failed to ensure the architecture and appurtenance are maintained.	A 152		

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A 152	Continued From page 23 Findings Included: Observation on at 6:12 am showed the light in # would not turn on. Interviewed on at 6:13 am Staff B (Caregiver) stated "the light works but sometimes I take the bulb out because the residents will have it on all night." Observation on at 6:14 am showed Staff B unscrewed the light bulb from the hallway and walked over to the light in # and screwed the bulb in. Observation on at 6:17 am showed paint disturbances in # near Resident #4 bed. Observation on at 6:20 am showed Resident # 4 had no nightstand on his side of the room. Observation on at 6:21 am showed cracked tiles in the hallway near # . Also, there was a closet door stored against the wall in the same hallway. (photographic evidence obtained) Observation on at 6:22 am showed an unsecured storage closet that had an air soft gun (BB gun), laundry softener and two cans of paint. Interviewed on at 6:23 am the Administrator stated, "I just opened it because I know y'all like to check." Observation on at 6:30 am showed	A 152		

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A 152	Continued From page 24 there were cracked tiles in the common/ living room area. Also, the storage cabinet next to the couch had unsecured nails and tools stored in the drawers. (photographic evidence obtained) Observation on at 6:31 am showed unsecured cleaning supplies in the kitchen area (glass cleaner, power foaming kitchen cleaner, cleaner bleach, Resolve , expert foam carpet cleaner). (photographic evidence obtained) Observation on at 9:10 am showed Administrator and Staff C (Caregiver) removed unsecured cleaning supplies from the kitchen area to a secure place. Facility was able to correct while on site. Observation on at 6:45 am showed the backyard had unsecured wood panels, a mattress was leaning against the shed with a chair in front, box filled with miscellaneous items, commode, silver tarp was on the ground, unsecured propane tank, unsecured gasoline containers filled with gas, shovel, and wood panel. (photographic evidence obtained) During the exit interview on 9:20 am the Administrator stated Resident #4 signed a waiver that he didn't want a nightstand in his room. When asked for the documentation of this refusal of the nightstand, the Administrator could not provide it. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a	A 160		

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A 160	Continued From page 25 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 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	A 160		

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A 160	Continued From page 26 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 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	A 160		

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(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 27 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 interview and record review, the facility failed to maintain an admission discharge log which reflected the discharge address for residents who left the facility. Findings: A review of the admission/discharge log found no documented addresses for any resident who no longer lived at the facility. Interviewed on at 9:20 am, the Administrator stated, "How can I have the residents addresses if I don't have that information?" Class III	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966548	A. BUILDING: _____ B. WING _____	03/11/2025

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A 162	Continued From page 28	A 162		
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 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	A 162		

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A 162	Continued From page 29 semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˘ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference 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	A 162		

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A 162	Continued From page 30 made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. 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 sampled residents (Resident #1).	A 162		

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A 162	Continued From page 31 Findings Included: A review of Resident's 1 health assessment showed the resident was not an elopement risk. A review of the compliant database records showed Resident #1 left the facility on and the staff were unable to locate her. Resident #1 returned to the facility on . The resident had not been medically assessed as an elopement risk. A review of the compliant database further revealed that on Resident 1 left the facility without notifying staff and did not return until . In an interview on at 7:45 am Administrator stated, "I've been dealing with Resident #1 for about a year, trying to manage her behavior problems." Also, the Administrator stated Resident #1 had been leaving the facility without letting her know. A review of Resident's 1 health assessment showed one of the three pages was missing from the resident record. Interviewed on at 7:45 am the administrator was asked to provide Resident's 1 complete health assessment. The Administrator could not determine if the page she provided was the actual page for the latest health assessment. Class III	A 162		
A 182 SS=F	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation	A 182		

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A 182	Continued From page 32 (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one of three sampled staff could implement the emergency procedures (Administrator). Findings: Observation on at 6:35 am showed a generator inside of a backyard shed. Interviewed on at 6:36 am, the Administrator was asked to start the generator that would power the facility in the event of a loss of primary power. Interviewed on at at 6:37 am, the Administrator stated regarding Generator, "I'm not doing that I need help to go take it out of the shed. She further statted, "That's not fair, you coming here at 6 am and you think I wouldn't help the residents." On at 8:29 am, observation revealed Staff B showing the Administrator how to start the generator . Class III	A 182		