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
	AL11967412	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLANCA AZUZENA HOME CARE, INC	12414 SW 252 TERRACE HOMESTEAD, FL 33032

(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 biennial survey was conducted from through at Blanca Azuzena Home Care. The provider had deficiencies at the time of the survey.	A 000		
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	A 010		

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

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

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to discharge one of four samled residents who no longer met the continued residency criteria (Resident #4). Findings: Observation on at 5:47 AM found Resident #4 in a hospital bed. Observation on at 9:11 AM revealed the Owner and Staff B Caregiver attempted to assist Resident #4 with ambulation, but the resident was unable to stand and ambulate, even with assistance. Interviewed on at 9:11 AM the Owner stated that she (Resident #4) 'has her days'. A review of Resident #4's long term care program plan of care dated showed the resident was bedbound as of for 365 days. (Photographic evidence obtained.) A review of Resident #4's health assessment with a completion date of showed ( ), (OA), . The physical limitation showed gait imbalance. The status showed memory loss. The resident had precautions. The activities of daily living showed assistance needed with ambulation, bathing, , eating, self-care, toileting and transferring. The resident was not listed as bedridden .	A 010		

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A 010	Continued From page 5 A review of the admissions and discharge log showed an admission date of . Interviewed on at 10:40 AM the Owner stated that the doctor came to the facility and that he had to put the resident under hospice care services. Class III]	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and	A 025		

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A 025	Continued From page 6 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 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 observation, record review and interview, the facility failed to provide personal supervision, and awareness of the general health and physical and emotional well-being of Resident #3 after he was allowed to travel alone, which resulted in his hospitalization with a . The facility failed to maintain a written record, updated as needed, of any	A 025		

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A 025	Continued From page 7 significant changes for Resident #4. Findings: 1) Observation on at 5:45 AM Resident #3 was not in the facility. Interviewed on at 5:53 AM Staff B (Caregiver) stated that Resident #3 was in the hospital after a . A review of Resident #3's hospital records dated showed: "Patient with a past medical history including but not limited to with bone . Patient came today for MCI follow-up he finishes session of to the 2 on C4 weeks ago also came for management care MCI team for follow-up; patient came to the by car, as per patient upon getting up from the care and felt a brief episode of when he closed the door his vision went dark and he collapsed from . Patient stated that before the syncopal episode and the day before his been he felt pretty much normal except some the night before, he also suffers from / . Denied post episode . Upon patient stated he hit the and right and on his . CT extensive osseous without or canal compromise. Multilevel changes. Patient with persistent right . inability to -bear underwent a lower extremity CT. Patient's status post right total with radiographically occult nondisplaced involving medial	A 025		

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A 025	Continued From page 8 metaphysis extending into the medial condyle. Additional nondisplaced of the and ." Interviewed on at 7:01 AM the Owner stated that Resident #3 was in the hospital. The Owner stated further that Resident #3 was going to a routine , , when he became , and in the doctor's office. The Owner stated that the Resident #3 used [a car service] to get to the , , by himself. Interviewed on at 10:56 AM the Sister-in-law stated, Resident #3 was transferred to rehabilitation from the hospital. The sister-in-law stated, "He three weeks ago at the [Institute] about three weeks ago in the valet parking. The problem is that he is heavy. He injured his right . Sometimes he used a walker. He goes to appoint by himself. [A car service] brought him to the [institute]." When asked if he was able to make decisions on his own, the sister-in-law stated, "Yes but no. This was the reason why I don't let him go to the doctor alone. He has everywhere." A review of Resident #3's primary care physician most recent notes from his (PCP) visits dated showed: "The patient is unable to leave Assisted Living Facility (ALF) [facility] due to his health , . . The patient suffers from a , , requiring constant supervision and assistance for all daily activities. Patients reports low and , , described as dull and persistent, with occasional exacerbations. Reports difficulty with mobility due to gait imbalance and neuropathic , ." Interviewed on at 3:18 PM the Owner stated that the staff that filled out the health	A 025		

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A 025	Continued From page 9 assessment made a mistake. The Owner stated, "A person with memory loss can't order [a car service]. You want to fine the facility, you can go ahead and do it. Everyone is complaining about you. I will fight the fine." Interviewed on at 10: 25 AM the Owner stated that it was a mistake by the doctor. The Owner stated further, I want to know if it was the house doctor or resident's (Resident #3) doctor that made the comment that he can be left alone and he needed supervision. A review of Resident #3's health assessment with a completion date of showed a diagnoses of Type II , , ( ), , , (HLP), , , . The physical status showed gait imbalance. The status showed memory loss. The resident had precautions. The Resident used a walker. The activities of daily living showed needed assistance with ambulation, bath, , and supervision needed with toileting, transferring, self-care and independent with eating. 2) Observation on at 5:47 AM found Resident #4 in a hospital bed. A review of Resident #4's long term care records showed resident was bedbound and had care. A review of Resident #4's progress notes showed no documentation of resident being bedbound and need of care.	A 025		

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A 025	Continued From page 10 Interviewed on at 10:40 AM the Owner stated that there was no documentation. Class II	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to arrange for health care for Resident #4. Resident #4 was bedbound and not under the care of hospice services. Findings: Observation on at 5:47 AM found Resident #4 in hospital bed. A review of Resident #4's long term care records showed resident was bedbound for 365 days and needed care.	A 027		

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A 027	Continued From page 11 A review of Resident #4's health assessment with a completion date of showed ( ), (OA), . The physical limitation showed gait imbalance. The status showed memory loss. The resident had precautions. The activities of daily living showed assistance needed with ambulation, bathing, , eating, self-care, toileting and transferring. The resident was not listed as bedridden or had any , 3, or 4 . Interviewed on at 10:40 AM the Owner stated that the doctor was supposed to comes to the house. Class III	A 027		
A 036 SS=D	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 , , , ,	A 036		

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A 036	Continued From page 12 , 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 . . 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, record review, and interview, the facility failed to ensure Staff B (Caregiver) provide services in a manner that reduces the risk of transmission of . . Findings: Observation on at 6:38 AM Staff B popped and touched the medications 25 MG and , 50 MG and place them into a small clear receptacle and observed Resident # 2 swallowed the medications. Observation on at 6:47 AM Staff B touched the medications again and offered and observed Resident #5 swallowed the medications. Observation on at 7:18 AM Staff B touched Resident #1's medications and offered him his medications and observed him swallow them. Interviewed on at 10:40 AM the Owner stated that Staff B was not to touch the	A 036		

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A 036	Continued From page 13 medications. Class III	A 036		
A 055 SS=D	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 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	A 055		

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A 055	Continued From page 14 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 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	A 055		

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	AL11967412	A. BUILDING: _____ B. WING _____	04/11/2025

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A 055	Continued From page 15 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, record review and interview, the facility failed to centrally store medications in a locked cabinet. Findings: Observation on at 5:55 AM medications (Cleanser) were found unlocked in a closet in the main hallway. Photographic evidence obtained. Observation on at 6:00 AM unlocked medications were found in a kitchen cabinet unlocked. Photographic evidence obtained. Observation on at 6:09 AM left alone with medications in a clear trash bag in the office. Observation on at 6:39 AM medication (, USP, 2%) was left next to Resident #2 while she was eating at the dining table for more than 10 minutes. The centrally storage medication policy states:	A 055		

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A 055	Continued From page 16 "All medications will be stored in a locked cabinet or closet." Interviewed on at 10:40 AM, the Owner stated that the medications found in the kitchen cabinet and closet were not actual medications. The Owner stated further that he was going to install a lock. Class III	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 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	A 093		

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A 093	Continued From page 17 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 necessary. However, the food items that enable	A 093		

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A 093	Continued From page 18 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: Based on observation, record review and	A 093		

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A 093	Continued From page 19 interview, the facility failed to follow the posted menu approved by a registered dietitian. Findings: Observation on at 6:38 AM Resident #2 served café con leche with bread and margarine. A review of the posted schedule dated showed bread and margarine, hot or cereal, juice and milk. A review of Resident #2's records found no signed refusal waiver for a therapeutic diet. Interviewed on at 10:40 AM when asked if Resident #2 had a signed waiver, the Owner stated, "Yes." Class III	A 093		
A 123 SS=D	429.27( ) FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds 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	A 123		

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A 123	Continued From page 20 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, 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	A 123		

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A 123	Continued From page 21 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 received for Residents #1. The facility failed to document and provide receipts of items purchased for Resident #1. The facility failed to establish a trust fund separate from the funds of the property of the facility which show be used for only Resident #1. The facility failed to furnish once every three months Resident #1 or his guardian, trustee or conservator, if any, a complete and verified statement of all funds and other property detailing the among and items received. Findings: Interviewed on at 7:00 AM the Owner	A 123		

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A 123	Continued From page 22 stated that four residents received . A review of Resident #1 records showed resident was receiving . Interviewed on at 7:32 AM when asked what happened to the Resident # 1's monies from , the Owner stated that sometimes he gives it to the family and sometimes the family tells him to keep it. The Owner stated further, "they don't want it. I buy cookies for the residents." When asked if he had receipts, the Owner stated, "Yes." When asked to provide the receipts, the Owner stated that he did not have any receipts. Class III	A 123		
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 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	A 152		

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A 152	Continued From page 23 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, record review and interview, the facility failed to maintain a safe living environment, free of hazards for five (#1, #2, #4, #5, #6) out of six sampled residents. Findings: Observation on at 6:02 AM pre-poured medications were found in a small clear receptacle in kitchen drawer accessible to residents. Photographic evidence obtained. Interviewed on at 6:02 AM Staff B (Caregiver) stated that it was her medication for her . Observation on at 5:50 AM cleaning supllies to include all purpose cleaner (1 gallon), and 1gallon bleach found in a kitchen cabinet and	A 152		

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A 152	Continued From page 24 in the bathroom, a spray bottle contianing bleach and brillo cleaner accessible to the residents. Photographic evidence obtained. Interviewed on at 10:40 AM the Owner acknowledged that the employee left medications in the kitchen drawer. 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 other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.	A 162		

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A 162	Continued From page 25 (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ␣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ␣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ␣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.	A 162		

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A 162	Continued From page 26 (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.	A 162		

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A 162	Continued From page 27 (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 the health assessment for Resident #1 after a significant change. The facility failed to maintain an accurate health assessment for Resident #4. The facility failed to maintain the documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney (POA) for Residents #1 and #2. Findings: 1) Observation on at 5:46 AM found Residents #1 and #2 in bed. A review of Resident #1's hospice records showed a . A review of Resident #1's health assessment section one showed "no" stageable checked. Interviewed on at 10:40 AM the Owner acknowledged that the health assessment was not updated. 2) Observation on at 9:11 AM Owner and Staff B Caregiver attempted to assist Resident #4 with ambulation, but the resident was	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967412	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLANCA AZUZENA HOME CARE, INC	12414 SW 252 TERRACE HOMESTEAD, FL 33032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 28 unable to stand and ambulate with assistance. Interviewed on at 9:11 AM the Owner stated that she (Resident #4) has her days. A review of Resident #4's long term care plan showed the resident was bedbound for 365 days. A review of Resident #4's health assessment with a completion date of showed (OA), . The physical limitation showed gait imbalance. The status showed memory loss. The resident had precautions. The activities of daily living showed assistance needed with ambulation, bathing, , eating, self-care, toileting and transferring. The resident was not listed as bedridden or had any , 3, or 4 . However, Resident #4 was unable to stand with assistance from the Owner and Staff B. 3) A record review of Resident #1's contract showed it was signed on by his son. A review of Resident #1 records found no power of attorney on file. A record review of Resident #2's contract showed it was signed by her daughter. However, there was no documentation of POA on file. Interviewed on at 10:40 AM the Administrator acknowledged that the power of attorneys were not in their files.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967412	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 162	Continued From page 29 Class III	A 162		