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 _____	R 05/14/2025

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 revisit to 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 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,	{A 010}		

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

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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,	{A 010}		

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

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{A 010}	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based observation, 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 staff knowing Resident 1's whereabouts. Findings Included: Observation on at 6:54 am showed Resident #1 was seated at the dining table with three other residents prepared for medication assistance. A review of the facility progress notes 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 facility progress notes revealed that on Resident 1 left the facility without notifying staff and did not return until . In an interview with the Administrator on at 7:47 am when asked about the resident return to the facility from the hospital after the last elopement and behavioral disturbances. The Administrator stated, "she's been more calm; we gave her a 45 days' notice, the resident case manager is helping her along with the day program she attends to find another assisted living facility." The Administrator further stated, "they are only finding independent living facilities but still trying to find an assisted living	{A 010}		

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{A 010}	Continued From page 5 facility close by." A review of the facility progress notes dated - showed Resident #1 was sent to a nearby hospital on due to 'anger, agitation, and shouting at staff.' The resident was released from the hospital on and returned to the facility. A review of Resident 1's 45 Days' Notice to Relocate showed the Resident and Administrator signed and dated . The reasons listed on the notice were that the residents don't sign out when leaving the facility. The residents refuse to wear an air tag, the elopements are continuous, and the residents refuse to follow the facility rules and regulations. Interviewed on at 12:02 pm Resident #1 Case Manager stated, "I think the ALF is trying to accommodate her." The Case Manager further stated, "I had offered to look for a place and they were going to see how it goes." The Case Manager also stated the Resident wanted to live in an independent house and the case manager believes it not in the resident best interest to do so. Interviewed on at 5:13 pm Resident #1 Psychiatrist stated, she was aware of the resident recent elopements "she has been out of control." Uncorrected Class III	{A 010}		
{A 032} SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards	{A 032}		

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{A 032}	Continued From page 6 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. 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	{A 032}		

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{A 032}	Continued From page 7 develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must 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 observation, 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 according to the state policy regarding elopement and wondering residents. Findings Included: Observation on at 6:54 am showed Resident #1 was seated at the dining table with three other residents prepared for medication assistance. Resident #1 had no form of identification on their person that included their name, the facility's address, and telephone number. Further Observation revealed Resident	{A 032}		

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{A 032}	Continued From page 8 #1 had no air tag on her as well. A review of the facility records showed Resident #1 had a prior elopement she left the facility on and the staff were unable to locate her. Resident #1 returned to the facility on . A review of the facility records revealed that on Resident 1 left the facility without notifying staff and did not return until . A review of the facility's elopement policy and procedures showed that the facility will ensure that residents at risk of elopement would be advised of the iGPS watch to wear daily before leaving the premises. Further review of the policy showed the facility had no documentation of an elopement risk needing a form of identification on their person that included their name, the facility's address, and telephone number. Interviewed on at 8:42 am when asked about Resident #1 identification and air tag Staff C (Caregiver) stated "I don't see anything for [Resident #1], only [Resident #5, and Resident #4] have their air tags on them." Interviewed on at 12:02 pm Resident #1 Case Manager stated, "I think she does have an air tag, but she might've also taken it off." During the exit interview at 9:06 am the Administrator stated, "please don't cite this again or I'll be fined." Uncorrected Class III	{A 032}		

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{A 036}	Continued From page 9	{A 036}		
{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 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 implement adequate measures to prevent the spread of for one out of five sampled residents (Resident #2). Findings Included: Observation on at 6:56 am showed the Administrator assisted Resident #3 with her	{A 036}		

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{A 036}	Continued From page 10 medication. Resident #3 dropped one of her pills onto the ground. The Administrator picked up the pill off the ground and handed it to Resident #3. The Administrator proceeded to watch Resident #3 take and swallow the dropped pill. Interviewed on at 9:06 am the Administrator acknowledged that she had handed the resident a pill from off the ground. Uncorrected 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 [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and,	{A 054}		

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{A 054}	Continued From page 11 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, record review, and interview, the facility failed to maintain an accurate medication observation record for one out of five sampled residents (Resident #2). Findings Included: Observation on at 6:56 am showed the Administrator finished passing the medications to Resident #2. Further observations showed the Administrator signed the medication observation record (MOR). A review of the medication observation record (MOR) revealed that the medications scheduled for at 6 PM were signed on the MOR before the medications were given to the resident. In an interview on at 9:06 am during the exit conference the Administrator stated, "oh, was it." Uncorrected Class III	{A 054}		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records	{A 162}		

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{A 162}	Continued From page 12 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 semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their	{A 162}		

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{A 162}	Continued From page 13 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 made a good faith effort to obtain the required documentation from the Department of Children and Families.	{A 162}		

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 _____	R 05/14/2025

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

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{A 162}	Continued From page 14 (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 maintain an accurate and updated Resident Health Assessment for one out of five sampled residents (Resident #1). Findings Included:	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 162}	Continued From page 15 A review of the facility records showed Resident #1 had two prior elopements and from the facility and the staff was unaware of her whereabouts. A review of Resident 1's health assessment dated indicated that the resident was considered an elopement risk, marked with a red "X" over the elopement risk box, unlike the other entries on the form. A review of the facility progress notes dated - showed that Resident #1 was sent to the hospital on for behavioral disturbances. The resident was discharged on with new medication. Interviewed on at 7:47 am the Administrator stated, "they gave me a new health assessment for [Resident #1]." Interviewed on at 12:02 pm Resident #1 Case Manager stated she had recently visited the resident because she had a significant change and last month (,) the resident had a follow up visit. During the exit interview on at 9:06 am when asked about Resident #1 health assessment not being updated after the two recent elopements and hospital visits. The Administrator stated, "I think that was the one her doctor office sent me. They told me it was good for the year; the only thing they updated was the elopement risk." Uncorrected Class III	{A 162}		