

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments A re-licensure survey in conjunction with a generator monitoring was conducted at Golden Age Assisted Living Facility Corp on . The provider had deficiencies identified at the time of the survey.	A 000			
A 010 SS=G	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			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
A 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 on observation, interview and record review, the facility owner failed to be responsible for determining the continued appropriateness of residence for one out of six sampled residents (Resident #2). Findings included: On at 7:55 AM observed Staff C and Staff D (Caregivers) trying to get Resident # 2 out of bed to the bathroom, the resident was not able to assist with transfer. Also observed that the resident had a On at 7:56 AM Staff C stated, "He came a few days ago from the hospital and he is weak." On at 8:15 AM the Owner stated that the family had agreed to place him on hospice and that they were waiting for the resident to finish so that the doctor could refer him. On at 10:29 AM the Owner stated, "He needs total assistance at this time and needs medication administration. We have been giving him the medications in his I already spoke to his daughter." A review of facility records' revealed that Resident # 2 had been admitted to the facility on Further review showed that he was admitted to the hospital on due to retention and on due to associated and and on due to and acute injury.	A 010	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 010	Continued From page 5 Class II	A 010			
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 6 activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention for one out of six sampled residents (Resident # 2). Findings included: A review of facility records' revealed that Resident # 2 had been admitted to the hospital on _____ due to _____ retention and _____, on _____ due to _____ associated _____, and _____ and on _____ due to _____ and acute _____ injury. A review of Resident # 2 record revealed that there was no documentation written by the facility	A 025		

If continuation sheet 8 of 36

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 032	Continued From page 8 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 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 record review and interview, the facility	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 032	Continued From page 9 failed to conduct two elopement drills annually. Findings included: A review of facility records revealed that the facility had conducted an elopement drill on _____ and another one on _____. Over the course of one year (_____ to _____) the facility had only conducted one elopement drill. On _____ at 12:28 PM the Owner stated, "Yes, I was supposed to have done another one by _____." Class III	A 032			
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL _____. Residents for whom a physician has prescribed a physical _____ must have a written care plan for the use of the physical _____. The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the _____ applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of _____, or decline in mobility or function related to the use of the prescribed _____. (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical _____ annually, and documentation of _____	A 033			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 033	Continued From page 10 this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the Health Care Provider reviewed the appropriateness of the continued use of the physical annually for one out of six sampled residents (Resident # 1). The facility failed to have a written care plan for the use of physical within 14 days of the device being prescribed for one out of six sampled residents (Resident # 2). Findings included: On during tour of the facility, observed Residents # 1 and # 2 in bed with full side rails up. A review of Resident # 1's record revealed that Resident # 1 had a prescription for full side rails from . On at 10:05 AM, the Owner stated, "The nurse from hospice told me that the newest prescription for Resident # 1 was in his record." A review of Resident # 2's record revealed that he had a prescription for full side rails from . Revealed that there was no care plan for the use of physical . On at 10:54 AM the Owner stated, I have to do the care plan."	A 033			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 033	Continued From page 11 Class III	A 033			
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including _____ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 053	Continued From page 12 Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility that provided medication administration, failed to have a nurse to administer medications for two out of six sampled residents (Resident # 1 and # 2). Findings included: A review of the Medication Observation Record revealed that the facility staff was signing the medications for Residents # 1 and # 2. A review of staffs records revealed that all 4 staff were no licensed to administer medications. On at 10:29 AM the Owner stated, "Resident # 2 needs total assistance at this time and needs medication administration. We have been giving him the medications in his _____." Stated, "I already spoke to his daughter." On at 11:13 AM Staff C stated regarding Resident # 1, "We have to give him the medications in his _____ because hospice does not provide the service." On at 11:15 AM the Owner stated regarding Resident # 1, "I already spoke to his son, who is a doctor, he thinking about _____ a nurse to come and do it." Class III	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126			
(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 056 A 056 SS=D	Continued From page 13 59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056 A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 056	Continued From page 14 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 056	Continued From page 15 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow the Health Care Provider orders for one out of six sampled residents (Resident # 6). Findings included: A review of the Medication Observation Record for Resident # 6 revealed an order for Pyridostigmine BR 60 mg to be given every 8 hours, revealed that the scheduled time was 7 AM, 1 PM and 7 PM. The scheduled time was not according to the Health Care Provider instructions, from 7 PM to 7 AM there were 12 hours, from 7 AM to 1 PM there were 6 hours and from 1 PM to 7 PM there were 6 hours. According to Cleveland Clinic, Pyridostigmine is a medication that treats On at 12:29 PM the Owner stated, "I will talk to the pharmacy, they are the ones that wrote the times. You are right the times are wrong." Class III	A 056			
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 078	Continued From page 16 (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 078	Continued From page 17 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one out of five sampled staff (Administrator) had a negative statement in an annual basis. Findings included: A review of employee records revealed that the Administrator had the last negative statement on On at 12:31 PM the Owner stated, "I will tell him."	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 078	Continued From page 18 Class III	A 078			
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/13/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN AGE ASSISTED LIVING FACILITY CORP

**5970 NW 3 STREET
MIAMI, FL 33126**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 19 absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 20 facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 079	Continued From page 21 requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an accurate staffing schedule. Findings included: On _____ at 6:55 AM, arrived to the facility and observed Staff C and Staff D [Caretaker] taking care of six residents.	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 22 A review of the staffing schedule revealed that Staff D [Caretaker] was not listed, Staff E was listed. A review of the facility's roster revealed that Staff E was not listed, but Staff D was listed. On at 8:08 AM the Owner stated, "I put Staff E on the schedule but she never worked, she had not let me know that she did not even have a background screening. The new employee (Staff D) started today, and I must fix the schedule." Class III		A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s.		A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 081	Continued From page 23 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 081	Continued From page 24 facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126			
(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 081	Continued From page 25 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that one out of five sampled staff (Staff D) had completed a 2 hours pre-service orientation that cover topics that help the employee provide responsible care and respond to the needs of facility residents before interacting with residents. Findings included: On _____ at 6:55 AM arrived at the facility and observed Staff C and D [Caretakers] taking care of six residents (Residents # 1, # 2, # 3, # 4, # 5 and # 6).	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 081	Continued From page 26 On _____ at 6:55 AM Staff D stated that she had just started today. On _____ at 7:55 AM observed Staff D assisting Staff C to get Resident # 2 out of bed. During the length of the survey, from 6:55 AM to 12:38 PM, Observed Staff D assisting residents in the shower, walking, eating. A review of staffs' records revealed that Staff D had no pre-service orientation. On _____ at 10:39 AM the Owner stated, "I know that the pre-service was supposed to be done before she started, but she has experience." Class III	A 081			
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 161	Continued From page 27 employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to one out of five	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 161	Continued From page 28 sampled staff (Staff D) had an application of employment. Failed to ensure that one of five sampled staff (Owner) had a copy of her more recent level II background screening results on her record. Failed to ensure that one out of five sampled staff (Staff C) had a copy of the results of the level II background screening on record. Findings included: 1- A review of employee records showed that Staff D had no employment application. On _____ at 8:44 AM, the Owner stated, "She started today." 2- A review of employee records showed that the Owner had a Level II on record dated _____. A review of the background screening site revealed that she had a recent one from _____. On _____ at 12:33 PM the Owner stated, "I will print the newest one." 3- A review of employee records revealed that Staff C had no copy of the results of her background screening on record. A review of employee records showed that she had a level II background screening completed on _____ and she had no break in service. On _____ at 12:34 PM the Owner stated, "It is not in her record?" Class III	A 161			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126			
(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 29 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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 30 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		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 31 (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 record review and interview, the facility failed to have accurate health assessments for two out of six sampled residents (Resident # 1 and # 2). The facility failed to have documentation of the legal representative for one out of six sampled residents (Resident # 1).	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 32 Findings included: 1- A review of residents records revealed that Resident # 1 had been receiving hospice services since _____ with a diagnosis of _____. Care plan reviewed on _____ stated that he had a _____ on the right _____, on the healing process and was receiving _____ care three times per week and PRN (as needed). A review of the contract revealed that it had been signed by his son and there was no documentation appointing him as his legal representative. A review of the health assessment completed on _____ revealed that he had no _____, 3 or 4 _____. Revealed that the resident required assistance with self-administration of medications. Stated that the resident was on a low fat/low _____ diet without stating the consistency. On _____ at 11:25 AM spoke to Registered Nurse from hospice who stated that Resident # 1 had a _____ on the right _____, on the healing process and was receiving _____ care three times per week. She stated that the _____ was getting much better and had decreased in size. The _____ appeared on _____, and that at the time of the survey the _____ measured 2 cm x cm 0.2 cm, and that they had to keep documenting a _____, but it was a _____. On _____ at 11:13 AM Staff C stated, "He is eating puree now and we have to give him the medications in his _____ because hospice does not provide the service." On _____ at 11:15 AM the Owner stated, "I	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 33 already spoke to his son, who is a doctor, he thinking about a nurse to come and do it." On at 11:43 AM the Owner stated, "His son signed the contract. I must have asked him for the papers, or maybe the Administrator did." 2- a review of residents records revealed that Resident # 2 had a health assessment completed on that had no and , at the time the resident was independent with ambulation and eating, required supervision with transferring and assistance with the rest of the activities of daily living. The section 1 D (in your medical opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or facility) stated NO. The health assessment did not state that he had a . On at 7:55 AM observed Staff C and Staff D [Caretakers] trying to get Resident # 2 out of bed to the bathroom, the resident was not able to assist with transfer. Also observed that the resident had a . On at 7:56 AM Staff C stated, "He came a few days ago from the hospital and he is weak." On at 10:29 AM the Owner stated, "He needs total assistance at this time and needs medication administration. We have been giving him the medications in his . I already spoke to his daughter. He needs a new health assessment." Class III	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 180 A 180 SS=D	Continued From page 34 59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, , incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964 . The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml . The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with 's or related , and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the	A 180 A 180			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN AGE ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 5970 NW 3 STREET MIAMI, FL 33126		
(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 180	Continued From page 35 county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide the most approval of the comprehensive emergency management plan (CEMP). Findings included: A review of facility's records revealed that the most recent approval letter of the CEMP available was dated . The 2025 CEMP had been submitted on . On at 8:47 AM Owner stated, "Yes, this is the approval of the 2022, the administrator told me that everything was ok." On at 8:49 AM the administrator stated that the approval for 2023 was at the facility, but the Owner could not find it. Class III	A 180			