

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER LONGEVITY ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 16160 SW 304 ST HOMESTEAD, FL 33033		
(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 generator monitoring was conducted at Longevity Assisted Living Facility on The provider had deficiencies at the time of the survey.	A 000			
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	A 025			

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: AL11970508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER LONGEVITY ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 16160 SW 304 ST HOMESTEAD, FL 33033		
(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 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to offer personal supervision as appropriate for each resident, including Resident #1. The facility failed to maintain a daily observation of Resident #1's safety while on the premises and awareness of general health. Findings: Observation on _____ at 11:29 AM Staff C (Caregiver) alone with Residents #1 and Resident #2. Observation on _____ at 12:16 PM Staff C	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER LONGEVITY ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 16160 SW 304 ST HOMESTEAD, FL 33033		
(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 2 assisted Resident #2 in a wheelchair to the bathroom. Observation on _____ at 12:17 PM Resident #1 walked into the kitchen unassisted and unsupervised, accessed a sharp silver knife from the drawer, picked up a mango and peeled it while in her _____ at the dinner table. A review of Resident #1's urgent care reported dated _____ showed a date of birth of _____ and a diagnosis of _____ and right _____. The Cleveland Clinic states: "A _____ is a clouding of the lens of the _____, which is typically clear. For people who have _____, seeing through cloudy lenses is like looking through a frosty or fogged-up window. Clouded vision caused by _____ can make it more difficult to read, drive a car at night or see expression on a friend's _____." Interviewed on _____ at 1:03 PM the Owner stated that she thinks Resident #1 suffered from _____. The Owner stated further that the employee was assisting another resident in the bathroom. Interviewed on at 11:51 AM on _____ when asked if he knew the diagnoses of Resident #1 the Owner stated that he thinks she suffered from _____. Aging In Place states: "Kitchen safety is one of the most important types of home safety to practice for the elderly, next to bathroom safety. The kitchen can be very dangerous place for anyone, but for those 65 and older, it is even more so. This is, in part, due to the fact that a person's responses and physical abilities diminish	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER LONGEVITY ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 16160 SW 304 ST HOMESTEAD, FL 33033		
(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 3 as they grow older. Keep all cabinet doors and drawers closed when not in use. Keep knives and other sharp objects properly stored." Class III	A 025		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff C (Caregiver) was capable in implementing the emergency plan in the event of a power outage due to inclement weather, including hurricanes. Findings: Observation on _____ at 11:29 AM found Residents #1 and Resident #2 in the facility alone with Staff C. Observation on _____ at 11:52 AM Staff C was unable to start the generator. A review of Staff C personnel records showed training on _____ in Facility Emergency Procedures including Chain of Command and	A 182		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970508	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER LONGEVITY ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 16160 SW 304 ST HOMESTEAD, FL 33033			
(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 182	Continued From page 4 Staff Roles relating to emergency evacuation . Interviewed on _____ at 12:20 PM Spoke the Administrator stated that it would take him 30 minutes to get to the facility since his (Staff C) employee could not start the generator. Interviewed on _____ at 12:56 PM the Owner stated that Staff C was nervous and inquired if she could get another chance at starting the generator. The Hurricane season extends from through _____, according to the Florida Disaster database. Hurricane Season is the time of the year when tropical cyclones, tropical _____, tropical storms, and hurricanes develop. Class III	A 182			