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
	AL11967370	A. BUILDING: _____ B. WING _____	R 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL ALF #2	21280 OLD CUTLER ROAD CUTLER BAY, FL 33189

(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 second revisit to a re-licensure survey was conducted at Living Well ALF #2 on . A deficiency was found at the time of the visit.	{A 000}		
{AN275} SS=D	59A-36.022 FAC; 429.07(3)(c)3 FS LNS - Licensing 59A-36.022 Limited Nursing Services. Any facility intending to provide limited nursing services must obtain a license from the agency. 429.07(3)(c)3 A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to obtain a limited nursing services license to provide limited nursing services including check, administration, and medication administration for three facility residents (Residents #1, #2 and #5) Findings as follow: On at 9:00 AM the Owner stated, "I am a registered nurse, and I administer the medications to Hospice residents due to Hospice does not provide the service and, I check and administer the to Resident #5. He said he administered medications to the facility residents	{AN275}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{AN275}	Continued From page 1 through a Home Health Agency he works for. He added, "the facility does not have Limited nursing services, and it was not possible to apply for it until present deficiencies are corrected. I believed I could continue administering the medications to residents until obtaining the LNS services license. Today I will have a new nurse to administer the medications to the residents." A review of the medication observation record showed the initial "J" for Residents #1, #2. A review of the / log for Resident #5 showed the initials JG. A review of resident's records showed Residents #1, #2 needed medication administration and Resident #5 administration. A review of the facility's roster on background screening Clearinghouse showed the Owner listed. The Owner was also listed in the Roster of the Home Health Agency providing services to the facility. Class III	{AN275}		