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
	AL11966902	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY'S EXTREME CARE	6107 SW 26TH STREET MIRAMAR, FL 33023

(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 An unannounced Relicensure with Extended Congregate Care (ECC), Complaint (#2025004271) and Generator Monitoring survey was conducted on . Deficiencies related to the Relicensure and ECC were identified at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 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	A 032		

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A 032	Continued From page 1 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 failed to ensure there was documentation of the Administrator and Direct Care staff participating in the facility's elopement drills. The findings included:	A 032		

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A 032	Continued From page 2 A review of the facility's elopement drills provided by the Administrator revealed documentation a drill dated . Further review revealed there was no documentation of staff participated noted on that document. There were no other elopement drills provided by the Administrator. During an interview conducted with the Administrator on at 7:50 PM, she was informed that the elopement drill on file did not document the names of the participating staff. The Administrator acknowledged that the facility's drills needed to properly identify staff participation, including herself. Class	A 032		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from	A 160		

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A 160	Continued From page 3 which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C.	A 160		

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A 160	Continued From page 4 (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's . . . prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 160		

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A 160	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain records at the licensee's physical address in a manner that demonstrated its ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. This was evidenced by the facility's failure to maintain and produce a grievance procedure for receiving and responding to resident complaints and recommendations at the time of survey and the facility's failure to maintain an up-to-date admission and discharge log listing the names of all residents and the date of admission and discharge for 1 of 3 sampled residents (Resident #1). The findings included: 1) A review of the facility policies and procedures revealed the facility is to maintain documentation of all policies in a binder. Further review of the facility's policy and procedure binder revealed there was no documentation of the facility's grievance procedure for receiving and responding to resident complaints and recommendations. During an interview conducted with the Administrator on at 3:49 PM, she stated that she does not have access to that document on site, it was in her storage. At this time, she was informed that the documentation was required to be on site for review by the Agency. The Administrator acknowledged the findings. 2) A review of the facility's admission and discharge log revealed that Resident #1 was admitted to the facility from and was	A 160		

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A 160	Continued From page 6 discharged on . There was no other documenation of another admission in the log. A review of Resident #1's file revealed a demographic sheet and progress notes with an admission date of . Further review revealed a Resident Health Assessment (AHCA Form 1823) with a date of . During an interview conducted with the Administrator on at 6:15 PM, she acknowledged that Resident #1 was admitted to the facility twice in 2021 but the admission-discharge 6log only reflected the first admission. She further stated that she forgot to update the log with resident's second admission. Class	A 160		
A 161	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 employment application, with references	A 161		

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A 161	Continued From page 7 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 record review and interview, the facility failed to maintain the written work schedules and staff time sheets for the most current 6 months.	A 161		

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A 161	Continued From page 8 This was evidenced by the facility's failure to maintain a staff schedule for the months of , and . The findings included: A record review of the facility's staff schedules revealed there was no staff schedule present for the month of . Further review revealed there was no staff schedule on file for , . During an interview conducted with the Administrator on at 9:46 AM, she stated she had no schedule for or because she had two new hires. She further stated she manually handwrites the schedules every month, but did not get the chance to do these last two months. The Administrator acknowledged the findings. Class III	A 161		
AE206	59A-36.021(6) FAC ECC - Service Plans (6) SERVICE PLANS. (a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. (b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the	AE206		

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AE206	Continued From page 9 resident's health assessment obtained pursuant to subsection (5); the resident's unique physical, [illegible] and social needs and preferences; and how the facility will meet the resident's needs including the following if required: 1. Health monitoring, 2. Assistance with personal care services, 3. Nursing services, 4. Supervision, 5. Special diets, 6. Ancillary services, 7. The provision of other services such as transportation and supportive services; and, 8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences. (c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences. (d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to review and update extended congregate care (ECC) service plans quarterly to reflect any changes in condition. This was evidenced by the	AE206		

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AE206	Continued From page 10 facility's failure to maintain a quarterly service plan update for 1 of 2 sampled ECC residents(Residents #3). Additionally, the facility failed to the development of a written service plan that takes into within 14 days of 2 out 2 sampled ECC residents (Residents #) receiving services under the ECC license. The findings included: During and interview conducted with the Administrator on , at 9:26 AM she stated that she had two residents under the facility's ECC licensure (Resident #). At this time, the facility's ECC documentation was requested. A review of Resident #2's file revealed an admission date of . Further review revealed an initial ECC assessment and service plan dated . There was no additional documentation of a service plan follow up within 14 days of the resident receiving services. A review of Resident #3's file revealed an admission date of . Further review revealed an initial ECC assessment and service plan dated . There was no additional documentation of a service plan follow up within 14 days of the resident receiving services. Additionally, there was no documentation of the facility performing a quarterly review of the service plan for the years 2019-2025. During an interview conducted with the Administrator on at 7:55 PM, the Administrator acknowledged that the residents' files were missing the service plans. Class III	AE206		

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AE210	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , , , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the 2 of 4 sampled Direct Care staff (Staff B and D) providing care to residents the facility's ECC program completed at least 2	AE210		

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AE210	Continued From page 12	AE210		

hours of in-service training within 6 months of hire. Additionally, the facility failed to ensure the Administrator completed a minimum of 4 hours of continuing education every two years .

The findings included:

A review of the Administrator's file revealed a hire date of . Further review reveals a CORE licensure examination date of . There was no documentation of an inital ECC training on file for the Administrator, nor were there any continuing education trainings on file from 2007-2024.

A review of Staff B's file revealed a hire date of . Further review revealed there was no documentation of a mandatory 2 hour ECC training on file.

A review of Staff C's file revealed a hire date of . Further review revealed there was no documentation of a mandatory 2 hour ECC training on file.

During an interview conducted with the Administrator on at 7:58 PM, she was informed that she did not have her required ECC inital and continuing education training, as well as Staff B and D were missing the required 2 hour ECC in-service. She stated that she thinned her personnel file so she did not have the documentation for her training on site. She further stated that Staff B and D perform care for residents in the ECC program. Subsequently, the Administrator acknowledged that Staff B and D must have the required 2 hour ECC in-service.

Class III

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ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966902	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain the employment status of 1 of 4 sampled staff (Staff E) in the agency's background screening clearinghouse. The findings included: A review of the facility's Extended Congregate Care (ECC) documentation revealed the facility's ECC nurse (Staff E) was for services with the facility as of . A review of Staff E's revealed there was no documentation of a hire date on file. Further review revealed a background clearinghouse result that did not have the facility documented as a former or current employer. There was a the ECC contract on file for . However, there was no other documentation on file that verified Staff E's employment was maintained with the facility.	ZZ814		

Agency for Health Care Administration

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ZZ814	Continued From page 2 During an interview conducted with the Administrator on at 7:58PM she was informed that Staff E did not have their employment with the facility registered in the background clearinghouse. Additionally, she acknowledged that Staff E was as the ECC Nurse. The Administrator stated that Staff E had been working for the facility as the ECC Nurse since when the contract started. Subsequently, the Administrator acknowledged that Staff E must have their employment registered in the background clearinghouse if she was providing services in the facility. Unclassified	ZZ814		