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
	AL11967763	A. BUILDING: _____ B. WING _____	R 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALF FAMILY CARE II, CORP	13480 SW 89TH TERRACE MIAMI, FL 33186

(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-visitsurvey was conducted at ALF Family Care II Corp. on . Deficiencies were identified at the time of the survey.	{A 000}		
A 025 SS=G	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.	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (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, interviews and record reviews, the facility failed to provide monitoring of diets, and have written records of significant changes for one out of eight sampled resident (# 8). Findings included: Observation on at 2:50pm showed that Staff E was sitting next to Resident #8. When Staff E stepped away from Resident #8, Staff D or other employees would remain at Resident # 8 side. During an interview on10/30/2025 at 3:16pm Staff D stated that Resident # 8 and wanted	A 025		

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A 025	Continued From page 2 to go home. A review of Resident #8's health assessment dated showed that the resident was diagnosed with , , and . Her physical and mental limitations included memory loss, tiring when ambulating, and limited mobility. She was a risk but was not an elopement risk. Resident # 8 needed supervision with ambulation, eating, self-care, toileting, and transferring; and needed assistance with bathing and . Resident # 8 required a calorie-controlled diet. During an interview on at 3:30pm Staff F stated that Resident # 8 did not drink water if it was not flavored and brought food from home. A review of Resident #8's progress notes showed that the last progress note was dated . There was no documentation of resident refusal of her prescribed diet or notification to family or healthcare providers. During an interview on at 10:05am Resident # 8's Case Manager stated that the resident only participated in day care services from 7:00am to 7:00pm. According to him, her daughter gave her the medications prior to and after the day care services. According to the case manager, although she was diagnosed with , Resident #8 was not on any medication, and the doctor stopped her in 2024. There were no monitoring orders for Resident #8. The case manager stated she last saw Resident # 8 on at the facility where she was assessed at low risk of elopement, however she	A 025		

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A 025	Continued From page 3 was a risk. Class II	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of	A 030		

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A 030	Continued From page 4 its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 5 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both	A 030		

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A 030	Continued From page 6 are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a	A 030		

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A 030	Continued From page 7 facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman	A 030		

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A 030	Continued From page 8 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that 2 out of 9 sampled residents (#5, and #6,) retained the use of their living quarters and that 1 out of 9 (# 8) received adequate and appropriate health care. Findings included: 1) Observation on at 2:45 pm showed that Resident #5 and Resident #6 reside in Room	A 030		

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A	Continued From page 9 #3. Residents # 5 and # 6 were male and dress in men's clothing. In # there was a closet, which contained women's clothing. During an interview on at 2:45pm Staff D stated that the clothing in the closet belonged to the staff at the facility. 2) Observation on at 2:50pm showed that Staff E was sitting next to Resident #8. When Staff E stepped away from Resident #8, Staff D or other employees would remain at Resident # 8 side. During an interview on10/30/2025 at 3:16pm Staff D stated that the only Resident that receives medications from staff was Resident #9, everyone else gets their medications from the hospice nurse. Staff D further stated that Resident # 8 and wants to go home. A review of Resident #8's health assessment dated showed that she was diagnosed with , , . Her physical and mental limitations include memory loss, tiring when ambulating, and limited mobility. She was a risk but was not an elopement risk. Resident # 8 needed supervision with ambulation, eating, self-care, toileting, and transferring; and needs assistance with bathing and . Resident 8 further needed assistance with self-administration of medication. A review of Resident #8's progress notes showed that on Resident #8 and received a small on her right forehead. Emergency services were called but it was not clear if Resident #8 was taken to the hospital for	A 030		

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A 030	Continued From page 10 further treatment. The facility documented that emergency services notified residents daughter that she could get at the hospital. Observation on at 3:20pm showedb Staff E was assisting Resident # 8 with ambulation, transferring, and toileting. A review of Resident #8's record showed that the last progress note was dated . There was no documentation of any changes in condition that required one-on-one supervision of Resident # 8 with ambulation, transferring, and toileting. Class III	A 030		
A 054 SS=G	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care	A 054		

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A 054	Continued From page 11 provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that it kept a medication observation record for two out of eight sampled residents who required assistance with self-administration of medications (Resident #7 and Resident #8). Findings include: An observation on at 2:39PM revealed that a bottle of 40mg prescribed to Resident #7 was found in the staff room of the facility. During an interview on at 3:01PM, Staff D (Caregiver) confirmed that she assisted Resident #7 with his medication. During an interview on at 3:34PM with the Administrator and the Owner, the Administrator stated that the day care residents did not receive medication while they were at the facility. When asked how the facility kept track of what medications the staff assisted with, the Owner stated that they were waiting for Staff C to arrive because "she knows more".	A 054		

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A 054	Continued From page 12 During an interview on at 3:31PM, Staff C was asked if the facility had any medication observation records for the day care residents, to which she stated no. A review of Resident #7's and Resident #8's files revealed that there were no medication observation records for either resident and that both required assistance with self-administration of medication. Class II	A 054		
{A 055} SS=F	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for	{A 055}		

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{A 055}	Continued From page 13 whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it	{A 055}		

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{A 055}	Continued From page 14 is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to centrally store and secure medications in a locked cabinet. The facility failed to secure medication for one out of eight sampled residents (Resident #7). Findings Include: An observation on at 2:39PM revealed that a bottle of 40mg prescribed to Resident #7 was found in the staff room of the facility. An observation on at 2:51PM	{A 055}		

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{A 055}	Continued From page 15 revealed that the facility's medication cabinet was unlocked and medication cabinet key was left on a hook located directly next to the cabinet; both could have been accessed by anyone in the facility An observation on at 2:52PM revealed that Staff D re-opened the unlocked medication cabinet and then proceeded to lock it. During an interview on at 2:52PM, Staff D (Caregiver) stated that she could use the key to lock the medication cabinet. Uncorrected Class III	{A 055}		
A 058 SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies	A 058		

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A 058	Continued From page 16 related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such	A 058		

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A 058	Continued From page 17 consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation and record review the facility failed to correct a Class III deficiency for its medication practice. The facility failed to ensure centrally stored medication was kept secure and medication observation records were maintained for two out of eight sampled residents (Resident #7 and Resident #8). Findings include: An observation on at 2:39PM revealed that a bottle of 40mg prescribed to Resident #7 was found in the staff room of the facility. An observation on at 2:51PM revealed that the facility's medication cabinet was unlocked and medication cabinet key was left on a hook located directly next to the cabinet, both could have been accessed by anyone in the facility During an interview on at 3:31PM, Staff C was asked if the facility had any medication observation records for the day care residents to which she stated no. A review of Resident #7 and Resident #8's files revealed that there were no medication observation records for either resident and they both required assistance with self-administration of medication. A review of the facility's previous deficiencies	A 058		

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A 058	Continued From page 18 revealed that the facility received a Class III deficiency for medication storage and disposal on . Class III	A 058		
A 093 SS=E	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed	A 093		

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A 093	Continued From page 19 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide	A 093		

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A 093	Continued From page 20 notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to document resident refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal for one out of nine sampled residents. (#8)	A 093		

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A 093	Continued From page 21 Findings included: Observation on at 2:50pm showed that Staff E was sitting next to Resident #8. When Staff E stepped away from Resident #8, Staff D or other employees would remain at Resident # 8 side. During an interview on at 3:30pm Staff F stated that Resident # 8 does not drink water if it is not flavored and brings food from home. A review of Resident #8's health assessment dated showed that she was diagnosed with , , . Her physical and mental limitations included memory loss, tiring when ambulating, and limited mobility. She was a risk but was not an elopement risk. Resident # 8 needed supervision with ambulation, eating, self-care, toileting, and transferring; and needed assistance with bathing and . Resident # 8 required a calorie-controlled diet. A review of Resident #8's record showed that the last progress note was dated . There was no documentation of compliance or non-compliance with the prescribed diet or notification to family or healthcare providers. A review of Resident #8's progress notes showed that on Resident #8 and received a small on her right forehead. During an interview on at 10:05am Resident # 8's Case Manager stated that the resident only participates in day care services from 7:00am to 7:00pm. According to him her daughter gives her the medications prior to and	A 093		

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A 093	Continued From page 22 after the day care services. According to the case manager, although she is diagnosed with , she is not on any medication, and the doctor stopped her in 2024. There were no monitoring orders for Resident #8. Class III	A 093		
{A 152} SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	{A 152}		

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{A 152}	Continued From page 23 keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment, free of hazards to the residents. Findings included: Observation on at 2:39pm showed that the staff room was kept unlocked. In the staff room Staff E Kept an Inhaler unlocked in a small dresser. During an interview on at 2:42pm Staff D stated that Resident # 5 was under hospice care but was able to ambulate, and Resident #6 was able to ambulate as well. Observation on at 2:45pm showed Resident # 5 and #6 reside in # . # had an exit to the rear patio. Across from the exit there was a shed that had no locking mechanism. Located in the shed were boxes of chemical cleaners, paint buckets/pales, tools, a shop vacuum, mortar mix, canisters, concentrators, walkers and wheelchairs amongst other items. (photographic evidence obtained) Observation on at 2:47pm showed that the facility also had a pool. There was safety	{A 152}		

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{A 152}	Continued From page 24 mesh fence around a portion of the pool. The safety mesh fences were not on the rear of the pool, and the pool could be assessed. (photographic evidence obtained). Observation on at 2:58pm showed that in the hallway leading to an activity room there was a laundry closet that had the laundry machines and cleaning supplies. The closet had locks but were unlocked and assessable to residents. There were cleaning detergent and household chemicals in the unlocked closet. During an interview on at 3:16pm Staff D stated that Resident #8 was a day care participant, known for ,g and that's why someone needed to be with her. Uncorrected Class III	{A 152}		
A 162 SS=E	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records 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,	A 162		

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A 162	Continued From page 25 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 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	A 162		

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A 162	Continued From page 26 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 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. (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	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967763	A. BUILDING: _____ B. WING _____	R 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALF FAMILY CARE II, CORP	13480 SW 89TH TERRACE MIAMI, FL 33186

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A 162	Continued From page 27	A 162		

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 observation, interview, and record review the facility failed to maintain an accurate and up to date health assessment for two out of nine sampled residents (#2 and #8)

Findings included:

1)

Observation on at 2:45 pm showed that there were six residents and two day care participants at the facility.

During an interview on10/30/2025 at 2:45pm Staff D stated that there were five hospice residents and that facility.

Observation on at 2:46pm showed that Resident # 2 was bedridden.

A review of Resident # 2's health assessment

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A 162	Continued From page 28 dated showed that Resident # 2 was under hospice care. Resident # 2 needed total care with ambulation, bathing, _, eating, self-care, toileting, and transferring. Resident vs. 2 was on a puree diet and had . precautions. Resident # 2's assessment showed that they needed assistance with self -administration of medications. A review of Staff D's and Staff E 's employees records showed that they both received training with assisting resident with self-administration of medications. Neither Staff D nor Staff E were licensed health care providers. During an interview on10/30/2025 at 3:16pm Staff D stated that the only Resident that received medications from staff was Resident #9, and that everyone else receiveds their medications from the hospice nurse. Staff D further stated that Resident # 8 and wanted to go home. 2) Observation on at 2:50pm showed that Staff E was sitting next to Resident #8. When Staff E stepped away from Resident #8, Staff D or other employees would remain at Resident # 8 side. A review of Resident #8's health assessment dated showed that she is diagnosed with , , . Her limitations include memory loss, tires when ambulating, and limited mobility. She is a risk but was not an elopement risk. Resident # 8 needs supervision with ambulation, eating, self-care, toileting, and transferring; and needed assistance with bathing and _. Resident 8 needed assistance with self-administration of	A 162		

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A 162	Continued From page 29 medication. During an interview on at 10:05am Resident # 8's Case Manager stated that Resident #8 only participated in day care services from 7:00am to 7:00pm. The case manager last saw Resident # 8 on at the facility where she was assessed at a low risk of elopement and was a risk. The case mangers' only concern was Resident # 8 mental decline. Uncorrected Class III	A 162		
A 180 SS=E	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	A 180		

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A 180	Continued From page 30 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 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 observation, interview and record review, the facility failed to ensure to have a written comprehensive emergency management plan (CEMP). Findings Included: Observation on at 2:45 pm showed that there were six residents and two-day care participants at the facility. There were two staff members at the facility at the time of survey entrance.	A 180		

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A 180	Continued From page 31 During an interview on10/30/2025 at 2:45pm Staff D stated that there were five hospice residents at the facility and that four of them were bedridden. During an interview on10/30/2025 at 2:55pm Staff D pointed at the monoxide detector and did not know how to test the devices, when asked to show were the monoxide detector was and to test the device for operability. During an interview on at 3:34PM with the Administrator did not know what a CEMP was and was waiting on Staff C to arrive because "she knows more". Observation on at 3:34pm showed that there was no CEMP plan avaibble for review. A review of the county's plan verification pages shows the CEMP status as "profile in development." Class III	A 180		
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	A 182		

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A 182	Continued From page 32 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff were trained in their duties and able to implement the emergency management plan. One of eight sampled staff (staff D). Findings Included: Observation on at 2:45 pm showed that there were six residents and two-day care participants at the facility. There were two staff members at the facility at the time of survey entrance. During an interview on10/30/2025 at 2:45pm Staff D stated that there were five hospice residents at the facility and that four of them were bedridden. During an interview on10/30/2025 at 2:55pm Staff D pointed at the monoxide detector and did not know how to test the devices, when asked to show were the monoxide detector was and to test the device for operability. Class III	A 182		