

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/10/2025
NAME OF PROVIDER OR SUPPLIER GABLES MANOR INDEPENDENT INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1535 VENETIA AVENUE CORAL GABLES, FL 33134		
(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 revisit survey was conducted at Gables Manor Independent Inc. on . Deficiencies were identified at the time of the survey.	{A 000}		
A 031 SS=E	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's	A 031		

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: AL11943019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/10/2025
NAME OF PROVIDER OR SUPPLIER GABLES MANOR INDEPENDENT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 VENETIA AVENUE CORAL GABLES, FL 33134		
(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 031	Continued From page 1 appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, that facility failed to document care coordination from a third party documenting the names of the licensed professional rendering services for two out of five sampled residents (#2,	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/10/2025
NAME OF PROVIDER OR SUPPLIER GABLES MANOR INDEPENDENT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 VENETIA AVENUE CORAL GABLES, FL 33134		
(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 031	Continued From page 2 and #3). Findings included: Observation on _____ at 6:50am showed that there were five residents at the facility and three out of the five were under hospice care. A review of Resident #2's health assessment dated _____ showed that she needed medication administration and total care with eating. Resident #2 needed puree diet with honey thick liquids. A review of Resident # 2's records showed that she was under hospice care and needed her medications crushed. A review of the medication observation record (MOR) for Resident # 2 and showed that the medications were ordered for 9:00am. The initials "NP", "YA", and "EN" appeared marked on the different days where medications were administered. On the MOR _____ page only "EN" and "YA" signed the record. A review of Resident #3's health assessment dated _____ showed that she needed medication administration and assistance with eating. Resident #3 needed puree diet with honey thick consistency. A review of Resident #3's records showed that she was under hospice care and needed her medications crushed. A review of the MOR for Resident #2 and showed that the medications were ordered for 9:00am. The initials "NP", "YA", and "EN" appear marked	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/10/2025
NAME OF PROVIDER OR SUPPLIER GABLES MANOR INDEPENDENT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 VENETIA AVENUE CORAL GABLES, FL 33134		
(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 031	Continued From page 3 on the different days where medications were administered. On the MOR page only "EN" signed the record. During an interview on _____ at 7:00 am Staff C stated that nurses were coming in between 8:30am and 9:00am to give Residents #2 and #3 their medications. Staff C stated that he knew some of the nurses but not all of them because one of them was new. When asked why the hospice nurses were not signing there names in the MOR, Staff C stated that he did not know. During an interview on _____ at 8:25 am the Administrator suggest that state should do more to require the nurses to sign the records, because she does all she can. Class III	A 031			