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
	AL11943123	A. BUILDING: _____ B. WING _____	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NSPIRE HEALTHCARE KENDALL	9400 SW 137TH AVENUE 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 LNS Monitoring survey was conducted at Nspire Healthcare Kendall on12/29/2025. Deficiencies were identified at the time of the survey.	A 000		
A 075	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing or use of an automated external defibrillator as otherwise permitted by law.	A 075		

AHCA Form 3020-0001

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

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A 075	Continued From page 1 (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on Observation and interview, the facility failed to ensure that there was an Automated External Defibrillator in working order at the facility. Findings: Record review of the facility's census revealed that the facility is licensed for 54 residents. The ALF regulations state that an assisted living facility licensed with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator ( ). On at 12:00, an was observed being taken by the DON from a wall in the medication room. The was labeled as nonfunctioning and expired. On at 12:00, when interviewed, the DON stated that when an is needed, they use a crash cart. A crash cart is a mobile medical trolley containing essential drugs and tools for immediate life support during emergencies like . The facility did not have another portable . Class III	A 075		
A 151 SS=F	59A-36.014(2) FAC Physical Plant - Existing Facilities (2) EXISTING FACILITIES. (a) An assisted living facility must comply with the	A 151		

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A 151	Continued From page 2 rule or building code in effect at the time of initial licensure, as well as the rule or building code in effect at the time of any additions, modifications, alterations, refurbishment, renovations or reconstruction. Determination of the installation of a fire sprinkler system in an existing facility must comply with the requirements described in section 429.41, F.S. (b) A facility undergoing change of ownership is considered an existing facility for purposes of this rule. This Statute or Rule is not met as evidenced by: Based on Observation and Interview, the facility failed to ensure that all existing architectural, mechanical, electrical and structure systems, and appurtenances are maintained in good working order. The facility failed to maintain the appearance the wall had patches of peeling paint and loose wallpaper Findings: On at approximately 8:35AM furniture was observed in the hallway of the rooms of the residents. In addition, peeling paint and loose wallpaper were observed on the walls. On at approximately 8:35AM, when interviewed, Staff C stated that she had no idea why the furniture was in the hallway. Staff C stated you would have to ask the maintenance department" On at approximately 9:40AM the Administrator, when interviewed stated that the furniture observed along the hallway was from her office. The facility flooring was being redone from carpeting to tile. The hallway would be cleared of the Furniture.	A 151		

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A 151	Continued From page 3 On prior to the Exit Conference, the hallway was observed to be cleared of the furniture observed at 8:35AM. The peeling paint and the loose wallpaper were still observed. On at 12:00, on Interview during the exit conference, the Administrator acknowledged the peeling paint and wallpaper. She stated that they would take care of it. Class III	A 151		
A 161 SS=D	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 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	A 161		

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A 161	Continued From page 4 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 Observation, Interview and Record Review, the facility failed to ensure that a copy of license and certification of a nursing personnel was maintained in the personnel record. Furthermore, the facility failed to provide documentation of a negative examination documented on an annual basis for 2 out of 3 sampled staff.	A 161		

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A 161	Continued From page 5 Findings On at 8:30 AM, Staff B and C were observed at the facility. Both staff members were on the facility's roster. On at 9:25AM, the Administrator arrived at the facility. Record review of the Administrator revealed that the last exam documented was Record review for Staff B, and Director of Nursing (DON) revealed that the last exam documented was Record review of Staff C revealed that there was not an updated Nursing license or certificate in the personnel file. The latest document revealed an expiration date of On at 1:30 PM, when interviewed about the testing, the Administrator questioned if the testing was to be done yearly. On at 1:30 PM when interviewed, the Administrator stated that the License Practical Nurse (LPN) Staff C must have an updated license, but it was not filed. The Administrator stated that she would investigate it. Class III	A 161		