

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HIALEAH ALF INC

**158 WEST 8 STREET
HIALEAH, FL 33010**

(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 052 SS-I	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into	A 052		

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: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 052	Continued From page 1 the dispensing cup of the (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 052	Continued From page 2 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 052	Continued From page 3 the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that staff followed procedures for assistance with self-administration of medication for 10 out of 18 sampled residents (Resident #2, #4, #5, #8, #10, #12, #13, #14, #16, and #18). Findings include: 1) An observation on _____ at 7:40 AM revealed that during Resident #8's medication pass, Staff D (Caregiver) touched each of Resident #8's pills when she removed them from the _____ pack and placed them into a medicine	A 052	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 052	Continued From page 4 cup. Staff D did not inform the resident of the medication name or dosage. The resident's 10 MG tab then on to the floor. Staff D did not notice that the pill had on the floor and continued the medication pass. An observation on at 7:42 AM revealed that Staff D did not observe Resident #8 finish his medication. Staff D signed off on all of the resident's morning medication with her faced completely down, as the resident finished his medication. As Staff D collected Resident #8's medication supplies, the pill was left on the floor, unnoticed. During an interview on at 7:45 AM with the Assistant Administrator, she was informed that Staff D had signed off on a medication that had on the floor, to which she stated that Staff D had recently been retrained on medication. An observation on at 7:45 AM revealed that Staff D did not implement hygiene following the medication pass for Resident #8; she did not wash her or change her gloves. A review of Staff D's employee record showed that she last completed a training update for assistance with self-administration of medication on . A review of Resident #8's resident record revealed that he did not have a waiver to opt-out of being told his medication name and dosage. 2). Observations on from 7:00 AM to 8:47 AM revealed that Staff C (Caregiver) and	A 052	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 052	Continued From page 5 Staff D completed multiple medication passes for Residents #2, #4, #5, #10, #12, #13, #14, #16, and #18 and did not implement hygiene between the residents: 7:00 AM: Staff D assisted Resident #2 with a medication pass; she touched each pill as she removed it from its pack and then placed it into a medicine cup for consumption. 7:10 AM: Staff C dropped Resident #10's medication on to a table, in which she picked the pill up with her and placed it into a medicine cup for consumption. 7:15 AM: Staff C assisted Resident #18 with a medication pass; she touched each pill as she removed it from its pack and then placed it into a medicine cup for consumption. 7:17 AM: Staff C assisted Resident #13 with a medication pass, in which she placed her inside of a medicine bottle and removed a pill with her . She then placed it into a medicine cup for consumption. Staff C did not wash her . 7:26 AM: Staff D assisted Resident #12 with a medication pass; she touched each pill as she removed it from its pack and then placed it into a medicine cup for consumption. 7:59 AM: Staff D assisted Resident #5 with a medication pass; she touched each pill as she removed it from its pack and then placed it into a medicine cup for consumption 8:29 AM: Staff D assisted Resident #16 with a medication pass; she touched each pill as she removed it from its pack and then placed it into a medicine cup for consumption. 8:31 AM: Staff D assisted Resident #4 with a medication pass; she touched each pill as she removed it from its pack and then placed it into a medicine cup for consumption. 8:38AM: Staff D assisted Resident #14 with a medication pass; she touched each pill with her	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 052	Continued From page 6 gloved as she removed it from its pack and then placed it into a medicine cup for consumption. During an interview on at 8:47 AM with Staff D, she continued the practice in which she would remove the medication, place it into her before she placed it into the cup. When informed of her error, she stated "Oh okay". 3). An observation on at 7:10 AM revealed that Staff C provided Resident #10 a dose of Geri- SF 100 MG using a ¾ ounce unlined cup. Staff C did not measure the liquid dose as she completely filled the cup. A review of Resident #10's medication observation record revealed that he is prescribed 10 milliliters (0.34 ounces) of Geri- SF 100 MG every six hours. According to Kaiser Permanente, "Symptoms of overdose may include: extreme drowsiness, blurred vision, , slow/shallow breathing, 4). Observations on from 7:26 AM to 8:47 AM revealed that after Staff D conducted a medication pass for Residents #3, #12, #14, #17 and #18, Staff C would provide the residents with their medication and then breakfast. Staff C poured the into a ¾ ounce unlined cup and then provided it to the residents. She did not measure the liquid dose as she completely filled each cup. A review of Residents #3, #12, and #17 medication observation record revealed that they should have received 30 milliliters (1 ounce) of	A 052	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 052	Continued From page 7 , twice a day. A review of Resident #18 medication observation record revealed that he should have received 10 milliliters (0.34 ounce) of , twice a day. A review of Resident #14 medication observation record showed that he was prescribed to receive 15 milliliters (half ounce) once a day. According to the National Library of Medicine, " ", cramping, and are the most common symptoms of a overdose."	A 052		
A 053 SS=G	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing,	A 053		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 053	Continued From page 8 must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that only licensed staff administered medications to six out of eighteen sampled Residents. (Residents #2,3,6,8,12 and 16). Findings include: 1) Observation on _____ at 7:00 a.m. revealed Staff C (caregiver) placed medications for Resident #2 in a bowl of colored cereal with dried marshmallows and milk. Further observation revealed Staff D (caregiver) spoon-fed Resident #2 his medications in the cereal. A review of Resident #2's Medication Observation Record (MOR) showed that the resident was prescribed _____ 81 mg, _____ GLY 200 mg, Omega-3- _____, Esters, EIG 1G,	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 053	Continued From page 9 50 mg, 1000 Mcg, B6 100 mg, and D 1.25 mcg. A review of Resident #2's health assessment dated revealed diagnoses of , History of Sleep D Deficiency, , and of the Native, and Seborrhic , Resident #2 required assistance with bathing, eating, self-care (grooming), toileting, and needed assistance with self-administration of medication. 2) Observation on at 7:12 a.m. revealed Staff C placed medications for Resident #3 in a cup of yogurt and milk. Further observation revealed Staff D spoon fed Resident #3 his medications in the yogurt. A review of Resident #3's MOR showed that the resident was prescribed Sod Cap 100 mg, tab 10 mg, Sol 10 mg/15, Lorazepan tab 1 mg, SacubValsar tab 49-51 mg, AER HFA, tab 100 mg, 81 mg tab 400 mg, tab 3.125 mg, and Clopidrogel tab 75 mg. A review of Resident #3's health assessment dated revealed diagnoses of Dependence, Hyponatremia, Diastolic, Left , Left Hypertrophy, Hypertensive , Solid and	A 053		

AHCA Form 3020-0001
STATE FORM

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 053	Continued From page 12 50, 81 mg, calc 20 mg, 25-100 mg, 3.125 mg, 0.125 mg, 100 mg, 2.5 mg, 25 mg. A review of Resident #12's health assessment dated revealed diagnoses of Unspecified Protein Calorie and Permanent The Resident required supervision with ambulation, toileting, and transferring. The resident required assistance with bathing, self-care (grooming), and self-administration of medication 6) Observation on at 7:26 a.m. revealed Staff C placed medication for Resident #16 in a bowl of hot cereal. Further observation revealed Staff D spoon fed Resident #16 his medication in his cereal. A review of Resident #16's MOR showed that the resident was prescribed 8.6 mg, 0.4 mg, Calc 20 mg, Mes 2 50 mg, 100 mg, sod dr 500 mg, 20 mg, 325 mg, Metoprolol succ er 25 mg. A review of Resident #16's health assessment dated revealed diagnoses of of of Bone, and Localized Enlarged The Resident required assistance with ambulation, bathing, self-care (grooming), toileting, transferring, and self-administration of	A 053		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 053	Continued From page 13 medication. A review of the employee records showed that Staff C had completed six hours of Assistance with Self-Administration of Medication training on and the two- hour update on . Further review found no documentation of a medical provider's license. A review of the employee records showed that Staff D had completed six hours of Assistance with Self-Administration of Medication training on and the two hour update on . Further review found no documentation of a medical provider's license. Interviewed on _____ at 7:47 a.m., the Manager stated both staff had just completed the two-hour medication training update. Class II	A 053		
A 054 SS=I	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	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 054	Continued From page 14 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 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 staff maintained an up-to-date and accurate medication observation record for seven out of 18 sampled residents (Resident #2, #5, #6, #8, #9, #11, and #13). Findings include: 1) An observation on at 7:42 AM revealed that after Staff D (Caregiver) completed a medication pass for Resident #8, Staff D signed off on all of the resident's morning medications, including a treatment that was not taken yet. Staff D signed off on the medication observation record without observing Resident #8 take his medication. An observation on at 7:56 AM revealed that Resident #8 was treated with his	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 054	Continued From page 15 with assistance from Staff C (Caregiver). A review of Resident #8's medication observation record revealed that Staff D signed off on the resident's _____ which was later provided by Staff C. 2). During an interview on _____ at 6:10 AM Staff D was asked if there were any residents in the hospital, and stated Resident #9 was. A review of Resident #9's hospital record dated _____ revealed that the resident was first admitted on _____ and was still hospitalized. Further review revealed that Resident #9's medication observation record revealed that all of the resident's medication had been signed off as given on all days since _____, even though the resident had been in the hospital. 3). A review of Resident's #2's medication observation record revealed that the resident's _____ 50 MG only contained the directions of "Take by _____ one tablet twice a day". During an interview on _____ at 12:53 PM with the _____, Nurse, she confirmed that Resident #2's _____ 50 MG was ordered to be taken on an empty _____, one hour before breakfast or two hours after. 4). A review of Resident #5, #6, #9, #11 and #13's medication observation record revealed that it contained multiple handwritten medication instructions. There was no documentation of physician's orders in the resident records to verify the handwritten medications.	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 054	Continued From page 16	A 054		
	Class II			
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 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	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 055	Continued From page 17 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 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	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 055	Continued From page 18 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 observations, and interview, the facility failed to keep medications locked for seven out of eighteen sampled residents (Residents #3,5,6,11,13, 15 and 18). Findings included: Observation on _____ at 6:27 a.m. revealed an over-the-counter _____ lotion unlocked in the closet of Resident #15. Observation on _____ at 6:41 a.m. revealed unlocked medication (_____) in the refrigerator: Basaglar _____ injection prescribed to Resident #5; _____ 100 ml injection prescribed to Resident #6; Toujeo injection prescribed to Resident #8; Toujeo Solo 300 ml injection prescribed to Resident # 11; _____ injection 15 ml prescribed to Resident #13; Toujeo Max _____ 300 ml injection prescribed to resident #15; and _____ 100 ml injection prescribed to Resident #18. Observation on _____ at 7:55 a.m. revealed	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 055	Continued From page 19 a container of prescribed Silver Cream inside the armoire in # . Observations on _____ at 12:06 p.m. revealed a bottle of _____ shampoo in the unlocked closet that belonged to Resident #5 in a room shared by three residents. During an interview on _____ at 1:13 p.m., the Manager asked where the unlocked medication was and acknowledged the findings. Class III	A 055		
A 056 SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 056	Continued From page 20 contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 056	Continued From page 21 complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain updated Medication Observation Records (MOR) and failed to follow medication orders for seven out of 18 sampled residents (Residents #3,8,10,12,14,17,18). Findings included: A) Observation on _____ at 7:10 a.m. revealed Staff C (caregiver) poured the medication Geri- _____ -SF 100 mg in a small plastic cup	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 056	Continued From page 22 resembling a small espresso coffee cup, without measuring of 10 ml, and administering it to Resident #10. A review of the Cleveland Clinic consumer information database showed that Geri- () is an that decreases by thinning and loosening to make coughs more productive, thereby clearing airways. While uncommon, serious side effects of include severe reactions such as breathing problems or racing or trouble swallowing, itching or skin or cramps, and, or fainting, B) Observation on at 7:15 a.m. showed Staff C poured an unknown amount of into a small espresso coffee cup without measuring the amount, then gave the cup to Resident #18. A review of the MOR showed a prescribed dosage of 10 ml of Observation on at 7:29 a.m. showed Staff C poured an unknown amount of into a small espresso coffee cup without measuring the amount, then gave the cup to Resident #12. A review of the MOR showed a prescribed dosage of 30 ml of Observation on at 7:35 a.m. showed Staff C poured an unknown amount of into a small espresso coffee cup without measuring the amount, then gave the cup to Resident #8. A review of the MOR showed a prescribed dosage of 30 ml of	A 056	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 056	Continued From page 23 Observation on _____ at 7:47 a.m. showed Staff C poured an unknown amount of _____ into a small espresso coffee cup without measuring the amount, then gave the cup to Resident #17. A review of the MOR showed a t prescribed dosage of 30 ml of _____. Observation on _____ at 8:38 a.m. showed Staff C poured an unknown amount of _____ into a small espresso coffee cup without measuring the amount, then gave the cup to Resident #14. A review of the MOR showed a prescribed dosage of 15 ml of _____. A review of the Mayo Clinic database revealed that "taking less than the prescribed dosage of _____ for portal-systemic _____ (_____ -related _____), can lead to dangerous, potentially life-threatening increases in _____ ammonia levels that may result in _____. For _____, lower doses may fail to relieve or could worsen symptoms. Key risks of under-dosing _____ include: Uncontrolled ammonia levels in _____, leading to disorientation, _____, or _____; ineffective relief of _____, leading to continued or worsening symptoms, _____, and bloating; Reduced therapeutic consistency, making the underlying condition more difficult to manage." C) A review of Residents #5 and #11's MOR revealed that the prescribed medication _____ 50 mg was to be administered 30 minutes before breakfast on an empty _____. Further review showed that Staff D (caregiver) had administered and signed the MOR for both _____.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 056	Continued From page 24 residents, indicating the medication was given at 9:00 a.m. A review of the Mayo Clinic database revealed " _____ is taken orally once daily on an empty _____, 30 to 60 minutes before breakfast, to treat _____ and to support treatment of _____. When taken correctly, it helps restore normal _____ hormone levels and prevents symptoms such as fatigue, slow speech, _____ gain, _____, and _____ sensitivity. Incorrect administration reduces efficacy and may lead to _____ symptoms or more serious effects such as _____, _____, or _____ reactions." D) Observation on _____ at 7:02 am revealed Staff D dropped four pills into Resident #2's breakfast cereal with milk. A review of Resident #2's MOR showed the resident was prescribed _____ 50 mg; _____ 1000 mcg; _____ B6 100 mg; _____ D 1.25 mcg; _____ 8.6 mg at 7:00 am. Interviewed on _____ at 12:53 p.m., the _____ 50mg Nurse stated that the medication _____ was to be taken on an empty _____, 1 hour before or 2 hours after eating. A review of the Mayo Clinic database revealed " _____ is a benzothiazole neuroprotective medication used to treat _____ (_____) by slowing _____ progression and extending survival. It acts by inhibiting glutamate release and regulating neurotransmission. Common side effects include _____, _____, and _____ damage. It is taken	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 056	Continued From page 25 on an empty . 1 hour before or 2 hours after meals. is prescribed to treat (Lou Gehrig's) to extend life and delay the need for breathing support. works as a benzothiazole, it reduces damage to motor neurons by inhibiting glutamate release and inhibiting voltage-dependent channels. Common side effects include , fatigue, , and decreased count. It can cause injury, requiring monitoring via regular tests." Interviewed on . at 1:13 p.m. the Manager stated that Staff D had recently completed the two-hour medication update training. Class II	A 056		
A 058 SS=E	429.42() FS; 59A-36.023(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	A 058		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 058	Continued From page 26 agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies 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. 59A-36.023(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 59A-36.008, F.A.C., is documented by agency personnel 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 a class I or class 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	A 058		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 058	Continued From page 27 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 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 had four documented Class II deficiencies due to their medication practices. The facility also acquired one documented Class II deficiency due to their failure to adhere to dietary standards, which would require the facility to employ the consultant services of a registered or licensed dietitian and a licensed pharmacist or licensed registered nurse. Findings include: 1) Observation on _____ at 7:00 am revealed Resident #2, coughing while drinking water. Staff C and D (caregivers) came to assist him with medications and Staff D was observed placing four pills into the resident's bowl of _____ cereal. The resident was observed asking the staff to crush the medications, however they did not, and Staff D continued to feed him medications and cereal with the spoon. Resident #2 was observed coughing more and then retching repeatedly. Interviewed on _____ at 7:05 am Staff C stated "He can't use his _____," then continued feeding the resident the cereal and the pills with a spoon. A review of Resident #2's Medication Observation	A 058		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 058	Continued From page 28 Record (MOR) showed that the resident was prescribed 81 mg, GLY 200 mg, Omega-3- Esters, EIG 1G, 50 mg, 1000 Mcg, B6 100 mg, and D 1.25 mcg. 2) Observation on at 12:20 pm showed Resident #4 being fed by staff, dressed by staff, being transferred from his bed to a wheelchair by two persons and wheeled to the dining table. Further observation revealed Staff C dropped ten pills into the resident's puree breakfast. A review of Resident #4's medication observation record showed that the pills placed into the resident's puree were: 2 mg, ER 30 mg, 25 mg, 1 mg, 100 mg, 5 mg, 4 mg, 325 mg, 10 mg, 1000 mcg. 3) Observations on from 7:00 AM to 8:47 AM revealed that Staff C completed multiple medication passes for Resident #2, #4, #5, #8, #10, #12, #13, #14, #16, and #18 and did not implement hygiene, confirm the medication name or dosage and did not observe the resident's take the medication. Staff C also signed off on a medication that had on the ground and was not given and again on a medication that she did not assist with. Observations on at 7:02 AM and 12:18 PM revealed that the facility's staff did not follow the dietary requirements for Residents #2 and Resident #6. Resident #2 was fed cereal, with a mechanically soft diet order and Resident	A 058		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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	Continued From page 29 #6's food had liquid added to it, with a regular diet order. A review of the facility's deficiencies revealed that it obtained four Class II deficiencies for Medication - Assistance with Self-Administration and Medication - Labeling and Orders Medication-Administration, Medication- Records and one Class II deficiency for Food Services - Dietary Standards. 4) Observation on _____ at 12:18 p.m. revealed that Resident #6 's lunch had been served in a soup-like texture. Further observation revealed that Staff C was feeding Resident #6 his food. A review of Resident #6 's health assessment dated _____ revealed diagnoses of _____ Type II, High _____ History of _____ and _____. The resident was assessed as independent for eating, required supervision with ambulation, toileting, and transferring, and required assistance with bathing, _____, self-care (grooming), and self-administration of medication. The health assessment further revealed that Resident #6 was prescribed a regular diet. Interviewed on _____ at 12:28 p.m. revealed that the Assistant Administrator stated she did not know why Resident #6 's food had been liquefied. Staff C stated that perhaps he had an order for it, Staff E stated that it was better for him because the contents of the food were dry, so she added soup to make it liquid. When asked if she had contacted the doctor, she stated	A 058			

if continuation sheet 31 of 113

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 058	Continued From page 31 Dependence, and Adverse Effects of Unspecified Drugs, Medications, and Biological Substances. The health assessment further stated that the resident's prescribed diet was "Bland, No Tomato Sauce." A review of the menu dated _____ revealed that it included 1 cup of tomato with onion, with 1 tablespoon of _____. Further review revealed no documented substitution for that food item. An interview conducted on _____ at 3:22 p.m. with the health care provider's nutritionist revealed that Resident #14 had reported experiencing _____ when consuming tomato sauce. Class III	A 058			
A 075 SS=I	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 _____	A 075			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 075	Continued From page 32 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. (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 observations, interviews, and record review, the facility failed to have a functioning automated external defibrillator () on the premises, available for 17 of 17 residents who wished to be in the event of a medical emergency were they to become unresponsive. (Residents #2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18). Findings: In an interview on at 1:46 PM Staff E (caregiver) was asked to locate and test the automated external defibrillator (). She stated, "I think is in the office, let me check." An observation on at 1:47 AM showed Staff E located the automated external	A 075		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 075	Continued From page 33 defibrillator () in the office space against the wall. An observation on at 1:48 AM showed Staff E open the but was unable to follow the instructions and placed the unopened electrodes pads package down her shirt on the left side. In an interview on at 1:49 AM regarding the , Staff E stated, "I never used it before." An observation on at 1:50 AM revealed the 's battery expired in 2023, and electrodes pads and the spare kit expired in 2014 (Photographic evidence obtained) In an interview on at 1:51 AM Staff E was asked if she was certified on (), Staff E stated, "Yes, I am certified." Review of Staff E's record revealed () certification issued , expired . Further review showed that the certificate card stated that the training included skills. In an interview on at 11:58 PM, the Manager stated regarding the expired electrodes and battery, "I would get replacements as soon as possible." In an interview on at 11:59 PM, the Manager was asked how many residents at the facility did not have (), she stated, "as far as I know, no one has at the facility." When asked if this was the only device available in the building, she	A 075		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 075	Continued From page 34 stated, "Yes." Class II	A 075		
A 077 SS-I	429.176 FS; 429.52(), 59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 077	Continued From page 35 the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least _____ ; 2. If employed on or after _____ have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to _____, are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the _____ of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 077	Continued From page 36 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to _____, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not _____ serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393 .	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 077	Continued From page 37 This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to have an Administrator capable of handling the operation and maintenance of the facility operations, staff management, and resident care, to 18 of 18 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18). Findings included: 1) During a biennial relicensure inspection from through , noncompliance in 23 areas was identified, including one at Class I, and 12 at Class II. Immediate risk of harm and/or harm, was identified in the area of Resident Rights. Direct threat of harm was identified in the areas of Admissions-Continued Residency, Assistive Devices, Control Procedures, Medication- Assistance with Self Administration, Medication- Administration, Medication- Records, Medication- Labeling and Orders, Use of Personnel; Emergency Care, Food Service- Dietary Standards, Physical Plant-Safe Living Environment. 2) A review of facility, resident and hospital records showed Resident #1 , from a of the after he became unresponsive onsite and the staff waited two hours before calling 911. 3) Observation on at 6:00 a.m. revealed the facility was dark and the front gate bolted shut. Further observation revealed that after several minutes, Staff D (caregiver) came to the gate, then said that she had to find	A 077		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 077	Continued From page 38 the key so that she could open it and was observed walking into the facility. She emerged several minutes later to unlock the gate. Observation on at 6:30 a.m. revealed that there was no other egress from the facility. In an interview on at 11:33 AM, the Manager stated, "the current Census is 17 with two residents in the hospital." 4) On at 7:00 a.m. through observation revealed that the Administrator did not arrive at the facility during the visit and could not be contacted by telephone. Further observation revealed that only the Manager was present. A review of the Florida Health Finder database showed that the Manager was the Owner and Administrator of another assisted living facility. 5) On at 1:48 p.m., observation showed that Staff E (cook/caregiver) did not know how to use an Automated External Defibrillator (). Additionally, the electrodes and replacement pads were expired as of 2014 and the battery was expired as of 2023. A review of resident records revealed that all residents did not have a and would need to be revived if they became unresponsive. 6) Observation on at 6:39 AM revealed a dark substance resembling mold on the ceiling of the patio in the common area where residents gathered. A review of the Department of Health Inspection dated revealed an unsatisfactory maintenance report, with the facility given 72 hours to correct the conditions by cleaning the dark substance and repainting.	A 077	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026																						
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010																								
(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 077	Continued From page 39 Class II	A 077																								
A 079 SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: <table border="1"> <thead> <tr> <th>Number of Residents, Day Care Participants, and Respite Care Residents</th> <th>Staff Hours/Week</th> </tr> </thead> <tbody> <tr><td>0-5</td><td>168</td></tr> <tr><td></td><td>212</td></tr> <tr><td>16-25</td><td>253</td></tr> <tr><td>26-35</td><td>294</td></tr> <tr><td>36-45</td><td>335</td></tr> <tr><td>46-55</td><td>375</td></tr> <tr><td>56-65</td><td>416</td></tr> <tr><td>66-75</td><td>457</td></tr> <tr><td>76-85</td><td>498</td></tr> <tr><td>86-95</td><td>539</td></tr> </tbody> </table> For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregational care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168		212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079		
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																									
0-5	168																									
	212																									
16-25	253																									
26-35	294																									
36-45	335																									
46-55	375																									
56-65	416																									
66-75	457																									
76-85	498																									
86-95	539																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 079	Continued From page 40 facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 079	Continued From page 41 aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 079	Continued From page 42 safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility had failed to have enough qualified staff to provide resident supervision and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs. Findings included:	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 079	Continued From page 43 1) On _____ at 6:00 a.m., only two staff members were observed on duty caring for 17 residents. A review of health assessment data showed 6 residents needed assistance with ambulation, 12 needed assistance with bathing and _____, 11 needed assistance with grooming, nine needed assistance with toileting. Further review revealed that 17 residents needed assistance with medications. 2) On _____ at 6:00 a.m., observation revealed that when resident records were requested, Staff C (Caregiver) and Staff D (Caregiver) did not have access to them. On _____ at 6:45 a.m. observation revealed the Manager arrived and provided the resident records. Class III	A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 081	Continued From page 44 completed the required preservice orientation. The facility must keep the signed statement in the employee 's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 081	Continued From page 45 which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 081	Continued From page 46 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that its staff completed the required one hour of in-service	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 081	Continued From page 47 training for recognizing and reporting resident , neglect and , for one out of eight sampled staff (Staff E). Findings include: An observation on at 8:50 AM revealed that Staff E (Caregiver) could be heard yelling and cursing at Resident #3, #5 and #8, due to an allegation that the residents had used the restroom and left feces everywhere. During an interview on at 1:45 PM, Resident #8 confirmed that Staff E used loud offensive words towards him and the other residents. A review of Staff E's personnel record found no documentation that she had completed one hour of in-service training for recognizing and reporting resident , neglect and . Class III	A 081			
A 093 SS=H	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.frules.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	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 093	Continued From page 48 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 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	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 093	Continued From page 49 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 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	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 093	Continued From page 50 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 observation, interview and record review, the facility failed to ensure dietary needs were met for three out of 18 sampled residents (Residents #2, 6, 14). Findings Included: 1) Observation on at 7:02 a.m. revealed that Resident #2 had been served a bowl of mixed colored cereal with dried marshmallows and milk. Resident #2 was observed coughing while Staff D (caregiver) instructed him to sit at the table for breakfast and medication. Observation revealed Staff C (caregiver) placed four pills into the bowl of cereal. The resident was observed asking Staff C (caregiver) to crush his medication through gestures that resembled a closed fist pounding on the table, however Staff D fed the cereal/milk/medication mixture to the resident. Further observation revealed that after consuming the medications/cereal/milk, Resident #2 appeared to be having trouble swallowing and retched repeatedly. A review of Resident #2 's health assessment	A 093	

AHCA Form 3020-0001

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 093	Continued From page 52 dry, so she added soup to make it liquid. When asked if she had contacted the doctor, she stated no and added that she would have to ask the Manager. Interviewed on _____ at 12:30 p.m. the Manager revealed, regarding the caregivers, that "they had put some soup inside of his food to make it a little softer because he had problems eating the texture of the food and he sometimes kept food in his _____." A review of Resident #6 's progress notes revealed no documentation indicating that the resident had problems eating food whole in consistency or that had a history of retaining food in his _____. Further review revealed no documentation of a physician's order for liquefied food. A review of the posted menu dated _____ revealed a "Regular, Modified Therapeutic _____ -No Concentrated Sugar Diet," and listed the meal of the day as consisting of 4 ounces of steak or stewed beef, 1 cup of rice and beans, ½ cup of cassava, 1 cup of tomato/onion with 1 tablespoon of salad _____, and ½ cup of peaches. 3) A review of Resident #14 's health assessment dated _____ revealed diagnoses of drug-_____ movement _____, _____, Type 2 _____, D _____ Deficiency, _____, _____, _____ (_____), _____, _____ with Behavioral Disturbance, _____, _____ 's _____	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 093	Continued From page 53 Hypertensive Pectoris, Benzodiazepine Dependence, and Adverse Effects of Unspecified Drugs, Medications, and Biological Substances. The health assessment further stated that the resident ' s prescribed diet was "Bland, No Tomato Sauce." A review of the menu dated _____ revealed that it included 1 cup of tomato with onion, with 1 tablespoon of _____. Further review revealed no documented substitution for that food item. An interview conducted on _____ at 3:22 p.m. with the health care provider's nutritionist revealed that Resident #14 had reported experiencing _____ when consuming tomato sauce. Class II	A 093		
A 152 SS=I	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	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 152	Continued From page 54 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 height 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 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 maintain a clean and safe environment, free of hazards. Findings: 1) Observation on at 6:00 a.m. revealed the facility was dark and the front gate bolted shut. Further observation revealed that after several minutes, Staff D (caregiver) came to the gate, then said that she had to find the key so	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 152	Continued From page 55 that she could open it and was observed walking into the facility. She emerged several minutes later to unlock the gate. Observation on _____ at 6:30 a.m. revealed that there was no other egress from the facility. In an interview on _____ at 11:33 AM, the Manager stated, "the current Census is 17 with two residents in the hospital." 2) Observation on _____ at 6:39 AM revealed a dark substance resembling mold on the ceiling of the patio in the common area where residents gathered. Further observation revealed no other location in the facility where residents could congregate. A review of the Department of Health Inspection dated _____ revealed an unsatisfactory maintenance report, with the facility given 72 hours to correct the conditions by cleaning the dark substance and repainting. 3) An observation on _____ at 6:17 AM revealed broken shower tiles in # _____ where Residents # 2, #9, #12, #14 lived. An observation on _____ at 6:31 AM revealed a broken window screen by the outside common area. In an interview on _____ at 6:32 AM, regarding the broken window screen, Staff C (caregiver), "I took it apart and I broke it while I was cleaning them."	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 152	Continued From page 56 An observation on _____ at 6:53 AM showed unlocked laundry detergent, cleaners and de-greasers by the washer and dryer in the common area where residents congregated. In an interview on _____ at 6:55 AM regarding the cleaning supplies, Staff C stated, "Well, yes, they should be locked at all times." An observation on _____ at 12:49 PM showed that the facility's fence and rusted outdoor shed were dented in multiple areas. An observation on _____ at 2:00 PM revealed in _____ # paint discoloration near the overhead light source, and a damaged bathroom door. Further observation revealed the doorknob did not turn. An observation on _____ at 10:06 AM revealed unlocked cleaning equipment including brooms and mops hanging in a rack in the backyard, accessible to residents. An observation on _____ at 10:10 AM revealed two shopping carts in the backyard. (Photographic evidence obtained) Class II	A 152		
A 160 SS=D	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	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 160	Continued From page 57 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 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.	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 160	Continued From page 58 (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. (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.	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 160	Continued From page 59 (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. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that it maintained an admission and discharge log that contained the addresses to which residents were discharged. Findings include: During an interview on at 2:29 PM with the Manager, she was asked about the admission and discharge log that did not contain the discharge addresses. She stated that she did not know that they needed to have that. A review of the admission and discharge log revealed that the facility had documented discharge locations such as "wife's house", "other ALF (Assisted living facility)", and "daughter's house". Class III	A 160	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 162	Continued From page 60	A 162		
A 162 SS=D	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, 9. Name, address, and telephone number of the resident's health care practitioner 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	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 162	Continued From page 61 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 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 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	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 162	Continued From page 62 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 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 ensure that resident records and Health Assessments were kept updated for five of 18 sampled residents	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 162	Continued From page 63 (Residents # 3, 5,6,7,12). Findings: 1) A review of Resident #3's health assessment dated revealed a diagnosis of (). A review of the resident progress showed no updates indicating a change in condition for the resident's status. Interviewed on at 3:36 pm, the resident's Primary Care Provider stated that the resident had an "History of ." 2) An observation on at 6:20 AM, showed Resident #4 with full bed rails in the up position. Review of Resident #4's file revealed half bed rails orders only. 3) On at 6:28 a.m. Resident # 5's bed was observed having a half bed rail screwed in at the middle of the bed position, functioning as a full bed rail. Resident #5 stated he was unable lower the bed rails on his own. A review of the resident record revealed record revealed a prescription for a half bed rail. During an interview on at 6:28 am, Resident #5 stated he had an open on his and was unable to walk or get out of bed without his wheelchair. Observation at 12:35 pm revealed Resident #5	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 162	Continued From page 64 out of bed, in the common area seated in a wheelchair having lunch. A review of Resident #5 health assessment dated indicated the resident the resident is ambulatory with the use of a walker. Further review of the resident files revealed a physician's order for the use of half bed rails. 4) Observation on at 12:18 p.m. Resident # 6 was observed receiving his lunch in a soup like texture. Staff C (caregiver) was observed feeding him. A review of Resident #6's health assessment revealed the resident was prescribed a "Regular Diet". Further review of Resident #6 record showed no physician orders for liquefied foods. During an interview on at 2:30 p.m. The Assistant Administrator stated, "They put some soup inside of his food to make it a little softer, because he had difficulty with the food's texture and sometimes kept food in his". 5) Observation on at 6:14 AM showed Resident #7's bed against the adjacent bed, blocking the resident's ability to exit his bed. In an interview on at 6:15 AM, Staff C stated, "He does it by himself and is for his own safety." In an interview on at 11:19 AM, Resident #7 stated, "The bed was placed by someone else. I do not want that bed against my bed and I not sure why the bed was against my bed." A review of Resident #7's record revealed no	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 162	Continued From page 65 documentation of a prescription, consent or care plan for 6) An observation on _____ at 6:17 AM, showed Resident #12 with full bed rails in the up position. Review of Resident #12's file revealed a consent for half bed rails. There was no prescription for bed rails. Class III	A 162			
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 165	Continued From page 66 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459,	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 165	Continued From page 67 chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an incident report for three of 18 sampled residents (Residents #1, 4, and 9). Findings Included: A review of the admission discharge log dated	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 165	Continued From page 68 revealed that Resident #1 had become unresponsive at the facility. The resident was propped up on pillows and kept onsite for two hours until his breathing changed staff called Emergency Medical Services. The resident was hospitalized, intubated and following a massive A review of data from New York Presbyterian Hospital revealed, "People experiencing a may have or on one side of the body. They may exhibit signs of or become. They may also show signs of speech difficulty, fainting, extreme, and light sensitivity. Catching a early and getting help can be the difference between life and " A review of data from Dr. Oracle revealed, "Immediate surgical intervention or interventional is required for all (patients with life-threatening to control and prevent further damage." is the loss of from the system, which usually leads to It can occur due to injuries or aneurysms, resulting in extreme loss.) A review of the Agency for Health Care Administration's incident report database revealed no documentation of the occurrence. Interviewed on the Administrator stated the resident had at the hospital, and that she did not know she was required to file an Adverse Incident Report. 2) A review of Resident #4's progress notes dated	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 165	Continued From page 69 revealed that the resident had fainted and had been transported to an area hospital for treatment. A review of the Agency for Health Care Administration's incident report database revealed no documentation of the occurrence. Further review of Resident #4's progress notes showed only that Resident #4 was stable, was taking for a , was eating very well, and slept better on some days than others. 3) A review of Resident #9's progress notes dated revealed that "Resident #9 had been fine until , when we had to send him to the hospital. He was still in the hospital." Interview on at 9:30 a.m., the Administrator stated after Resident #9 had finished eating, he began experiencing signs of black in his adult briefs, in addition to a dark substance. A review of Resident #9's hospital record dated revealed that Resident #9 had been transported by Emergency Medical Services to [] Hospital. Further review showed that Resident #9 was a male with a history of , and . Resident #9 reported that he had black stools and experienced fatigue after a movement, as well as an episode of that appeared dark in color. Resident #9 was subsequently diagnosed with an upper , low hemoglobin count, and	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 165	Continued From page 70 community acquired , A review of the state Adverse Incident Reporting System (AIRS) on _____ revealed that the facility had not filed an incident report or a 15-day follow up for Resident #9's hospitalizations dated _____, or _____ Class III	A 165		
A 182 SS=F	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 This Statute or Rule is not met as evidenced by: 1) Observation on _____ at 6:00 a.m. revealed the facility was dark and the front gate bolted shut. Further observation revealed that after several minutes, Staff D (caregiver) came to the gate, then said that she had to find the key so that she could open it and was observed walking _____ into the facility. She emerged several minutes later to unlock the gate. Observation on _____ at 6:30 a.m. revealed that there was no other egress from the facility.	A 182		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 182	Continued From page 71 In an interview on _____ at 11:33 AM, the Manager stated, "the current Census is 17 with two residents in the hospital." 2) In an interview on _____ at 11:15 AM, Staff D was asked to locate and test the monoxide detectors. Observation revealed Staff D pointed to a fire extinguisher against the door and asked, "Is this what you are speaking about?" 3) In an interview on _____ at 11:31 AM, Staff F (caregiver) was asked for the census, she stated, "We have 14 residents." A review of facility records showed that there were 15 residents in house, with two additional residents in the hospital. Review of Staff F's file revealed a training certificate for Facility Emergency Procedures dated _____ Class III	A 182			
AL241 SS=E	429.075(); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the _____ agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the _____ agreement was sent to	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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	
AL241	Continued From page 72 the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that	AL241			

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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
AL241	Continued From page 74 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for () form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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	
AL241	Continued From page 75 within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the _____ of the facility to facilitate and assist the resident in attending _____ and arranging transportation to _____ for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms _____ to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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
AL241	Continued From page 76 significant change in the resident's behavioral health. i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation 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 appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort.	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
AL241	Continued From page 77 The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that its admission and discharge log identified its limited mental health residents. The facility also failed to implement a community living support plan for one out of 18 sampled residents (Resident #5) within 30 days of his admission. Findings include: 1). During an interview on _____ at 2:24 PM with the Manager she was asked who the mental health residents were because it was not indicated on the admission and discharge log. She stated that the facility did not have any mental health residents. She further stated that she would count any resident who saw a psychiatrist as mental health resident, but she was told to stop that. In a subsequent interview on _____ at 2:30 PM with the Manager, she confirmed that all of the residents had a _____ agreement and community living support plan. She then stated that it was new to her. A review of Resident #5's chart revealed that the resident was a mental health resident. A review of the admission and discharge log revealed that none of the mental health residents were identified.	AL241	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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
AL241	Continued From page 78 2). A review of Resident #5's community living support plan dated _____ revealed that it was completed for the resident's previous assisted living facility; the facility did not have it's own plan. A review of the admission and discharge log revealed that Resident #5 was admitted on _____. Class III	AL241		
A 000	Initial Comments A biennial re-licensure survey was conducted at Hialeah ALF from _____. Deficiencies were identified at the time of survey. Class 1 deficiency was found at tag #A030. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, _____, or _____ to a resident receiving care in a facility. The Class I non-compliance began on _____ /206. The facility Manager was notified of the Class 1 non-compliance on _____. The census at the start of the survey was 17 residents. The facility failed to assist a resident with acquiring adequate and appropriate health care.	A 000		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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	Continued From page 79 The resident was found to have a large , was intubated and . The facility also failed to prevent . The following is a description of the deficiencies found at the time of the visit: A0010, A0025, A0030, A0031, A0034, A0036, A0052, A0053, A0054, A0055, A0056, A0058, A0075, A0077, A0079, A0081, A0093, A0152, A0160, A162, A0165, A0182, AL241.	A 000			
A 010 SS=H	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 010	Continued From page 80 requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 010	Continued From page 81 in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care,	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 010	Continued From page 82 or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner. 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 010	Continued From page 83 living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine the appropriateness of continued residency for two out of 18 sampled residents (Residents #2 & 4). Residents #2 and #4 could not assist in attending to their own activities of daily living and needed medication administration. Findings Include: 1) Observation on _____ at 7:02 am revealed Staff D (Caregiver) dropped four pills into Resident #2's _____ breakfast cereal with milk. Resident #2 was observed coughing and asking the Staff to crush his medication. Further observation revealed Staff D spoon fed Resident #2 the cereal and medication mixture. After consuming the medication Resident #2 began coughing and retching. Further observation revealed Resident #2 was unable to use his _____ to lift his medications to his _____. Observations on _____ at approximately 8:00 am revealed Resident #2 asked for and received a glass of water, drank some of it and coughed/choked repeatedly. A review of Resident #2's Medication Observation Record (MOR) showed the resident was prescribed _____ 50 mg; _____ 1000	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 010	Continued From page 84 mcg; B6 100 mg; D 1.25 mcg; 8.6 mg at 7:00 am. A review of Resident #2's health assessment dated revealed diagnoses of (), Type II, Regurgitation, Valve Clip, The resident needed assistance with eating, ambulation, bathing, self-care (grooming), toileting, transferring, and needed assistance with self-administration of medication. Resident #2 was also identified as at risk for and had a prescribed diet of thin liquids with mechanically ground foods. A review of the Mayo Clinic database revealed, " () also known as Lou Gehrig's is a of the nervous system that affects cells in the and cord. often begins with twitching and in an arm or trouble swallowing, or slurred speech. Eventually affects the needed to move, speak, eat and breathe. People with may have of the involved with swallowing. This can lead to and . They are also at higher risk of getting food, liquids or saliva into the , which can cause. A can reduce these risks and ensure proper hydration and nutrition." Interview on at 7:05 am Staff D stated Resident #2 "cannot use his so we do things for him." Interviewed on at 10:15 am, Resident #2's primary care provider stated that she did not	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 010	Continued From page 85 know that Resident #2 had been choking while eating or taking medications. She stated that she did not know he could not use his _____ because the facility had not provided her with any of this information. She further stated that if the resident was not able to use his _____, he was not appropriate to live at the facility. She stated that she needed to place the resident into the hospital so that he could be evaluated for swallowing ability. 2) A review of Resident #4's health assessment dated _____ revealed the resident needed assistance with ambulation, bathing, _____, eating, self-care (grooming), toileting, transferring and with self-administration of medication. Further review revealed the resident was prescribed a puree diet. Observation on _____ at 12:20 pm showed Resident #4 being fed by staff, dressed by staff, being transferred from his bed to a wheelchair by two persons and wheeled to the dining table. Further observation revealed Staff C (caregiver) dropped ten pills into the resident's puree breakfast. A review of Resident #4's MOR showed that the pills placed into the resident's puree were: 2 mg, _____ ER 30 mg, _____, 25 mg, _____, 1 mg, 100 mg, _____, _____, 5 mg, _____, 4 mg, _____, 325 mg, 10 mg, and _____ 1000 mcg. A review of data from the National Library of Medicine revealed: "_____ is prescribed for _____; _____ is prescribed for _____"	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 010	Continued From page 86 _____ is prescribed for _____ and should be taken 30-60 minutes before breakfast; _____ is prescribed to help the body make new proteins and healthy _____ is prescribed for _____. _____ is prescribed for _____. _____ is prescribed for _____ enlargement; _____ is prescribed for iron deficiency _____. _____ is prescribed to treat moderate to severe _____. _____ is prescribed for red _____ cell production and _____ function." Observation on _____ at 11:55 am revealed that Resident #4 was given a spoon, and the food was placed in front of him. Resident #4 picked up the spoon, turned the spoon around in the food and then used his _____ to discard the food off the spoon. Further observation revealed that the resident was unable to feed himself over the next several minutes. Observation on _____ at 12:20 pm revealed that the tray of food was no longer there. Interviewed on _____ at 12:21 pm the Manager stated that Resident #4 did not want the food, so she had taken it away. Interviews on _____ at 12:20 pm the Manager was asked why Resident #4's food was pureed. She stated, "Because the doctor ordered his food to be that way and it is on the health assessment." When asked if Resident #4 needed assistance with feeding himself and if she knew what "assistance" meant, the Manager responded that "assistance" meant helping open or cut food, not feeding the resident (Sic). When asked why the staff had been feeding the resident, the Manager insisted that the resident had been feeding himself. Further review of Resident #4's health	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HIALEAH ALF INC

**158 WEST 8 STREET
HIALEAH, FL 33010**

(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 010	Continued From page 87 assessment dated . . . showed diagnoses of . . . , Balloon . . . , Angioplasty, and . . . Class II	A 010		
A 025 SS=I	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 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 025	Continued From page 88 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (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, interview, and record review, facility also failed to maintain an up-to-date written record that documented significant changes in residents' conditions, including illness that required medical attention or developments that resulted in initiation or modification of services for four out of 18 residents sampled (Resident #2, #4, #6, 9). 1) Observation on _____ at 7:00 am revealed Resident #2, coughing while drinking water. Staff	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 025	Continued From page 89 C and D (caregivers) came to assist him with medications and Staff D was observed placing four pills into the resident's bowl of cereal. The resident was observed asking the staff to crush the medications, however they did not, and Staff D continued to feed him medications and cereal with the spoon. Resident #2 was observed coughing more and then retching repeatedly. Interviewed on _____ at 7:05 am Staff C stated "He can't use his _____," then continued feeding the resident the cereal and the pills with a spoon. A review of Resident #2's Medication Observation Record (MOR) showed that the resident was prescribed _____ 81 mg, _____ GLY 200 mg, Omega-3- _____ Esters, EIG 1G, 50 mg, _____ 1000 Mcg, _____ B6 100 mg, and _____ D 1.25 mcg. Interviewed on _____, Resident #2's medical provider stated that the resident had _____, which could _____ his ability to swallow. She stated that she had not been informed that the resident could not use his _____ or that he was coughing or retching while swallowing. A review of data from Mayo Clinic shows that " _____ is a nervous system _____ that affects _____ cells in the _____ and _____ cord, causes loss of _____ control. _____ often starts in the _____, _____ arms or _____. Then it spreads to other parts of the body. _____ get weaker as more _____ cells die. This eventually affects chewing, swallowing, speaking and breathing." A review of Resident #2's health assessment dated _____ showed Diagnoses of _____, History of _____	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 025	Continued From page 90 Sleep _____ D Deficiency, _____, Atherosclerotic _____ of the native _____, and Seborrhheic _____. Resident required assistance with bathing, _____, eating, self-care (grooming), toileting, and assistance with self-administration of medication. 2) A review of Resident #4's progress notes dated _____ revealed that the resident had fainted and had been transported to an area hospital for treatment. Further review of the progress notes indicated that Resident #4 was stable, was taking _____ for a _____, was eating very well, and slept better on some days than others. There was no documentation of the hospitalization, and no documentation that the resident's health care provider was notified of the hospitalization. 3) Observation on _____ at 12:18 p.m. showed Resident #6 receiving his lunch, served as a soup-like textured beverage. Staff C was observed feeding him. A review of Resident #6's health assessment revealed the resident was prescribed a "Regular Diet". Further review of Resident #6's record showed no physician orders for liquefied foods. During an interview on _____ at 2:30 p.m., The Assistant Administrator stated that "they put some soup inside of his food to make it a little softer, because he had difficulty with the food's texture and sometimes kept food in his _____." Additional review of Resident #6's record found no documentation that the Primary Care	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 025	Continued From page 91 Physician was notified that the resident sometimes kept food in his 4) A review of Resident #9's progress notes dated showed, "Resident #9 had been fine until , when we had to send him to the hospital. He was still in the hospital." Interviewed on at 9:30 a.m., the Manager stated regarding the hospitalization that after Resident #9 had finished eating, he began experiencing signs of black in his adult briefs, in addition to , a dark substance. A review of Resident #9's hospital summary dated revealed that Resident #9 had been taken to the hospital by Emergency Medical Services. The hospital record stated Resident #9 was "...a male with a history of , and , who had presented to [] for black stools. [Resident #9] reported that he had black stools and experienced fatigue after a movement, as well as an episode of that appeared dark in color." Resident #9 was subsequently diagnosed with an upper , low hemoglobin count, and community acquired, Class III	A 025		
A 030 SS=K	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 92 (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 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;	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 93 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. 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,	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 030	Continued From page 94 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 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	A 030	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 95 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 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,	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 030	Continued From page 96 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 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 97 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 record review and interview, the facility failed to ensure the receipt of timely and appropriate health care for one of 18 sampled residents (Resident #1). Resident #1 after being unresponsive for two hours before rescue was called and he was transferred to the hospital. The resident _____. The facility also failed to treat six out of 18 sampled residents with dignity and respect (Residents # 1,2,3,5,7,8). The facility failed to ensure that residents lived free of _____. Findings: 1) A review of the hospital record from the admission showed _____. Resident #1 had a large _____ hematoma measuring up to 4.0 cm. The resident underwent	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 98 emergency surgery of the right frontoparietal and hematoma evaluation on to no avail. The resident was intubated, placed on the , and diagnosed with acute , failure by 4:34 pm, when he was placed on a . Further review revealed that Resident #1 never regained and was declared on . After a medical panel review, he was removed from life support on . Interviewed on at 2:40 pm, Staff E (caregiver) stated Resident #1 left the facility at around 9:00 am on , as he did almost daily. Staff E further stated that the resident was walking independently when he left but returned sometime around 10:30 or 11:00 am being pushed in his walker by his son. The resident was breathing, refused food or other intervention, and laid down. Staff E observed shortly afterward that Resident #1 could not open his or move, although he was breathing. Staff E stated that she smelled what she thought was on his breath, so she and another staff propped him up in bed so that he wouldn't choke if he and came periodically to check on him and reposition him. At around 12:30 pm when Resident #1 was unable to eat lunch, still was unable to speak or open his , and began to make deep snoring sounds, a staff person called Emergency Medical Services (). A review of the ambulance run record showed that was contacted at 12:50 pm on and arrived at Resident #1 at 1:03 pm. Interviewed on at 12:30 pm Resident #1's Primary Care Physician (PCP) stated Resident #1 was being treated for high	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 99 and He further stated that Resident #1 was a 2 pack per day smoker and denied the use of The PCP also stated he was unaware of the residents use of or of his and said the last time he saw the resident was some time in Interviewed on, Resident #1's son stated his father came to a nearby store at around 8:30 on as he did daily. He further stated that his father sometimes had a beer when they were together but he did not drink that day. He stated his father complained of a and felt so the son tried to push his father to the facility in his walker, but his father refused and wanted to walk alone. The son stated his father went to the facility between 10:30 and 11:00 am. A review of data from Dr. Oracle revealed, "Immediate surgical intervention or interventional is required for all patients with life-threatening to control and prevent further damage." (. is the loss of from the system, which usually leads to It can occur due to injuries or aneurysms, resulting in extreme loss.) 2) An observation on at 8:50 AM showed Staff C (caregiver) cleaning the bathroom area and screaming to Residents #3, #5, and #8, "You don't know how to [.] in the bathroom! Why?" Further observation revealed that when Staff C realized that she was seen screaming profanities at the residents, she lowered her voice and changed the subject. In an interview on at 1:45 PM,	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 100 Resident # 8 was asked about the day that Staff C was screaming in the bathroom area, Resident #8 stated, "Yes, I remembered everything that day, she said loudly using offensive words that the bathroom was dirty. This never happened before." Resident #8 appeared nervous, afraid and hesitant to share this information. Interviewed on 02/26/2026 at 2:00 p.m., Resident #5 stated that Staff C often yelled at Resident #3 because he didn't want to get out of bed. 3) An observation on 02/25/2026 at 6:12 AM revealed Staff D (caregiver) not knocking before entering room #3. An observation on 02/25/2026 at 6:13 AM revealed Resident #7's bed side-by-side against another bed, in room #3. In an interview on 02/25/2026 at 6:14 AM, Staff D was asked who had placed Resident #7's bed against the other bed, Staff C stated, 'He does it by himself and it is for his own safety.' Interviewed on 02/25/2026 at 11:19 AM, Resident #7 stated, "the bed is placed by someone else. I do not want that bed against my bed and I not sure why the bed is against my bed." (Sic) Review of Resident #7's health assessment dated 05/21/2025 showed diagnoses of ... Type II, ... He required supervision with ambulation, eating and transferring and assistance with bathing, ... self-care (grooming), toileting and with self-administration of medication. An observation on 02/25/2026 at 9:34 AM revealed Staff D changed adult brief for Resident	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 030	Continued From page 101 #5 on the bed without curtains or dividers between beds while assisting with personal grooming. Further observation revealed that Residents # An observation on 02/25/2026 at 9:35 AM revealed Staff D assisted Resident #8 with the bathroom door open and the resident was exposed. In an interview on 02/25/2026 at 9:37 AM, Staff C was asked about Resident # 5 and Resident #8 not being treated with dignity. She stated, "well, this is the only way I can do it." Review of Resident #8's health assessment dated 09/10/2025 showed diagnoses of Type 2, D deficiency, of Angiopathy, COVID, of , Benzodiazepine dependence, Tobacco and . The resident needed assistance with ambulation, bathing, self-care (grooming), toileting, transferring and with self-administration of medication. Review of Resident # 5's health assessment dated 01/22/2026 showed diagnoses of Type II (Non-Dependent), and . The resident requires supervision with eating. The resident needed assistance with ambulation, bathing, self-care (grooming), toileting, transferring and with self-administration of medication.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 030	Continued From page 102 An observation on 02/28/2026 at 12:02 PM revealed Staff F (caregiver) going into room # 2 with laundry in . Further observation revealed that Staff F did not knock before entering, revealing Resident #3 using the bathroom with the door open. Staff F proceeded to go through the bathroom area towards the room to place the laundry in the closet space, while Resident #3 was still sitting on the toilet. Review of Resident #3's health assessment dated 09/10/2025 showed diagnoses of dependence, Hyponatremia, , Left diastolic , Left hypertrophy, , Hypertensive Type (), , Obstruction , Heavy smoker, pectoris, , COVID-19, Hyponatremia, of , Benzodiazepine dependence, . The resident needed assistance with bathing, and assistance self-administration of medication. Class I	A 030			
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	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 103 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 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.	A 031			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 104 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 the facility failed to ensure that its third-party services properly secured medication and supplies, and documented services provided for five out of 18 sampled residents (Resident #6, Resident #8, Resident #13, Resident #15 and Resident #18). Findings include: 1). An observation on 02/25/2026 at 10:17 AM revealed that the Home Health Nurse left Resident #8's prep pads, Resident #13's syringes, Resident #18's needles, and Resident #15's two boxes of lancets	A 031		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 105 unattended on top of a deep freezer located in the dining area. 2). During an interview on 02/26/2026 at 2:14 PM with the Manager, she was asked for the third party's documentation that showed that Resident #6, Resident #13 and Resident #15 had their levels checked after _____, 7th, 2026, which was the last documented date of the log. The Manager responded that maybe the Home Health Nurse "put it somewhere" and that it wasn't a part of her paperwork, so she did not follow it. She further stated that maybe the Home Health Nurse took the papers with her, but she knew that she [the Home Health Nurse] completed the paperwork every day. A review of Resident #6, Resident #13 and Resident #15 _____ log revealed that the last documented log on file was from _____, 1st - 7th, 2026. Their files did not contain any additional _____ logs since then. Class III	A 031		
A 034 SS=H	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a	A 034		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 034	Continued From page 106 resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents had access to their assistive devices in their rooms when needed. In addition, there was no documentation of the assistive devices in the residents' records for two of 18 sampled residents (Resident #4 and Resident #5). Findings included: On 02/25/2026 at 6:24 a.m., Resident # 5 was observed lying in bed with a half bedrail screwed into the middle of the frame, which the resident could not remove without staff assistance. The bedrail was in the raised position. On 02/25/2026 At 11:00 a.m., two walkers, one bath chair and two wheelchairs were observed stored with laundry items in a room outside the residents' rooms, making them inaccessible for residents' use. On 02/25/2026 At 11:30 a.m., Resident #4 and Resident #5 were observed in the common area seated in wheelchairs talking with Staff C (Caregiver).	A 034		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 034	Continued From page 107 On 02/25/2026 At 6:27 a.m., During an interview Resident # 5 stated he was unable to put the bedrails down on his own. He further stated that he used a wheelchair and a walker, which was observed on the outside of the room out of reach of the resident. A review of resident records revealed that there were no orders on health assessment prescribing the use of wheelchairs for Resident #4 and Resident #5. (Photographic evidence was obtained). Class III	A 034		
A 036 SS-I	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an anticipated exposure to transmissible agents in , nonintact skin, and mucous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield.	A 036		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 036	Continued From page 108 (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility had failed to implement a hygiene program and had failed to ensure that two out of eight sampled staff (Staff C and Staff D) followed hygiene practices that would have reduced the risk of transmission of according to the facility's control policy. Findings included: 1) Observations on 02/25/2026 from 7:02 a.m. to 8:47 a.m. revealed that Staff D (Caregiver) assisted with self-administration of medication to multiple residents without engaging in proper -washing techniques: 7:02 a.m. - Staff D touched the medication while preparing it to be administered to Resident #2. 7:10 a.m. - Staff D dropped a pill on the table, picked it up with her , placed it in a cup, and provided it to Resident #10 for consumption. 7:12 a.m. - Staff D exited the kitchen area, returned, and began preparing medication for Resident #13 without changing her gloves. 7:23 a.m. - Staff D went outside the facility while wearing gloves, retrieved a bag of frozen yuca that had been hanging over the fence from an unknown individual, returned to the kitchen area,	A 036		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 036	Continued From page 109 and continued administering medication. 7:29 a.m. - Staff D was observed touching the medication while placing it into the cup medications for Resident #12, wearing the same gloves with which she had retrieved the bag of frozen yuca. 7:35 a.m. - Staff D prepared medication for Resident #8, dropped the medication on the floor, picked up the tube, placed it in the garbage, and continued assisting residents with self-administered medications. 7:38 a.m. - Staff D exited the kitchen entered Room #4, and administered , , to Resident #8. Staff D did not wash or sanitize her before giving the , , . 7:43 a.m. - Staff D exited Room #4 and returned to the kitchen area. 7:45 a.m. - During an interview with Staff D, she stated that she only worked in the kitchen and also assisted with bathing and breakfast. 7:48 a.m. - Staff C (caregiver) was observed administering an aerosol treatment after giving the residents breakfast while wearing the same gloves that she had been wearing in the kitchen. 7:59 a.m. - Staff D was observed touching the medication while placing it into the cup for Resident #5. 8:23 a.m. - Staff D obtained gloves to prepare medication for Resident #16; however, she was observed touching the medication while placing it into the cup. 8:31 a.m. - Staff D entered Room #3 and began preparing medication for Resident #6. She was observed touching each pill as she removed them from the pack. 8:38 a.m. - Staff D assisted with medication administration for Resident #14. She used gloves and was observed touching each medication, then placing them directly into the resident 's for self-administration.	A 036		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010	
(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)
A 036	Continued From page 110 An interview conducted on 02/25/2026 at 8:47 a.m. revealed that Staff D had been informed she could not touch medication with or without gloves. Staff D stated, "But I used sanitizer." A review of Staff D ' s personnel file revealed that she had received training in control on 09/22/2026, six hours of Assistance with Self-Administration of Medication training on 10/07/2024, and a two-hour update on 09/30/2025. Interview on 02/25/2026 with the Manager revealed that she was advised about the staff touching medication, and she stated, "Yeah, I don ' t know what happened with that." 2) Observations on 02/25/2026 from 7:02 a.m. to 8:23 a.m. revealed that Staff C (Caregiver) performed multiple tasks while assisting with self-administration of medication, including direct food handling, without engaging in proper -washing techniques. 7:02 a.m. - Staff C came from the kitchen wearing blue gloves and carried a bowl of mixed colored cereal with dried marshmallows, then spoon-fed Resident #2 his cereal. 7:12 a.m. - Staff C exited the kitchen wearing the same pair of gloves. She was observed holding a cup of yogurt for Resident #13 and spoon-feeding him without changing gloves. 7:19 a.m. - Staff C returned to the kitchen and began preparing a bowl of oatmeal using the same pair of gloves. 7:27 a.m. - Staff C entered Room #4 carrying	A 036	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010		
(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 036	Continued From page 111 breakfast while still wearing the same gloves from the kitchen. 7:29 a.m. - Staff C wiped the resident ' s while wearing the same gloves, placed the napkin in the bathroom garbage, returned, and spoon-fed breakfast to Resident #12. 7:45 a.m. - Staff C arrived from the kitchen to Room #2 wearing the same gloves to bring breakfast to Resident #8. 7:48 a.m. - Staff C was observed administering an aerosol treatment after giving the residents breakfast while still wearing the same gloves that she had been wearing in the kitchen. 8:23 a.m. - Staff C was observed exiting the kitchen and entering Room #1 wearing the same gloves. While in the room, she spoon-fed Resident #16 a bowl of cereal. A review of Staff C ' s personnel file revealed that she had received control training on 01/26/2026 and one hour of Nutritional and Safe Food Handling training on 07/09/2026. A review of the facility handwashing policy revealed the following: "1)Employees' must be washed for at least 20 seconds using soap and water A. Before and after contact with the resident (mandatory). B. After contact with , , visibly contaminated surfaces. C. After contact with objects and surfaces in the resident's environment D. After removing Personal Protective Equipment (gloves, gown, facemask, , protection). E. After using the restroom. F. After blowing one's , sneezing or coughing, G. Before eating or preparing food.	A 036			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER HIALEAH ALF INC		STREET ADDRESS, CITY, STATE, ZIP CODE 158 WEST 8 STREET HIALEAH, FL 33010			
(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 036	Continued From page 112 H. When their are visible soiled I. At the beginning and the end of each shift. J. After contact with animals or pets. Class II	A 036			