Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968485	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISA HOME CORP	13316 SW 112TH CT MIAMI, FL 33176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial survey was conducted at Isa Home Corp on . Dficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.	A 025		

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a written record, updated as needed, of any significant changes, or other changes that resulted in the provision of additional services for one out of six sampled residents (Resident #1). Findings included: During an interview on at 6:20am Staff B stated that Resident # 1 was in the hospital, when asked where she was. Staff B stated that Resident # 1 was weak and was taken to the hospital when fire rescue found her levels were abnormal.	A 025		

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A 025	Continued From page 2 A review of Resident # 1 's hospital records dated showed that she was diagnosed with , a , and macrocytic . According to the hospital record resident was treated by emergency medical services with 50% and because her level was at 20mg. At arrival at the hospital her level was between 50-70mg. The hospitalization occurred at 9:20am on . According to the Mayo Clinic would occur when your ( ) level too low for bodily functions to continue. would occur if you ate less than usual after taking your regular dose of medication. A review of Resident # 1's health assessment dated showed that she required "no concentrated sweets" diet. Resident #1 was diagnosed with . Resident # 1 was independent with ambulation, eating, self-care, toileting, and transferring. Resident # 1 only needed supervision with bathing and . A review of Resident # 1's health assessment dated showed that she no longer required "no concentrated sweets" diet, however a regular diet with regular texture and thin fluid consistency. Resident #1 was diagnosed with . Resident # 1 now needed assistance with ambulation, bathing, , toileting, and transferring. Resident # 1 needed supervision with eating and grooming. A review of Resident # 1's health assessment dated showed that she required a	A 025		

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A 025	Continued From page 3 control , diet with no added salt. Resident #1 was diagnosed with . Resident #1 now needed assistance with ambulation, bathing, , toileting, grooming and transferring. Resident # 1 needed supervision with eating. A review of Resident # 1's health assessment dated showed that she was on a regular diet with no added salt. Resident #1 was diagnosed with . Resident #1 now needed assistance with ambulation, bathing, and , Resident # 1 needed supervision with toileting, grooming and transferring. Resident # 1 was now independent with eating. A review of the posted menu showed that residents with needs would not receive nutrition with added sugar. Observation on at 9:50am showed that residents were given a watermelon juice mix with 15grams of added sugar. (photographic evidence obtained) During an interview on at 9:55am Staff B stated that all residents drank the juice mix, and that Resident #1 also received therapeutic shakes with added sugar sometimes. A review of the menu for showed that dinner consisted of soup, chicken salad, bread, tomatoes, and pudding was available to residents and on showed that breakfast consisted of juice, cereal, bread with butter, and milk. A review of records showed that a home health nurse came and check Resident # 1's levels and administer to Resident #1	A 025		

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A 025	Continued From page 4 on . The home health nurse had not come to check Resident # 1's levels or administers to Resident #1 on . During an interview on at 10:00am the Administrator stated that Resident # 1 health management organization sent them the health assessment, when asked why Resident # 1 had so many health assessments. The administrator stated that he understands, when asked how his staff would know what food and what assistance to give Resident # 1. When asked if he could tell which was Resident # 1's correct diet and ADL's from the health assessments he said he would have to call the nurse. A review of Residents # 1 recorded showed that on her ; her ; her ; her During an interview on at 10:30am the Administrator stated that the nurse comes to visit her and that he did not call the physician, when asked if the physician was notified of a significant loss in the resident. The administrator did not answer when asked at what point does the facility ability to provide assistance become too much for the facility to handle. Class II	A 025		
A 036 SS=E	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that	A 036		

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A 036	Continued From page 5 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 , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (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 failed to ensure that staff implemented hygiene and standard precautions in accordance with their control policies and procedures for one out of three sampled staff (Staff B). Findings included: Observation on at 6:56am Staff B assisted Resident # 5 with medications. Resident # 5 medications were in pack form, and each represented a day of the month. Staff B punched out the medications from day 12 one	A 036		

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A 036	Continued From page 6 by one into her and then into a cup for Resident #5 to self-administer. Observation on /20206 at 710am Staff B assisted Resident # 3 with medications. Resident #3 medications were also in pack form. Staff B punched out the medications from day 12 one by one into her and then into a cup for Resident # 3 to self-administer. On two occasions during the process piece of the foil covering stuck to the pill and Staff B removed them with her . A review of Staff B records showed that she completed her training on control on and her assistance with self-administration of medication training on . During an interview on 12:12pm Staff B stated that she will not do that again, when asked about control and her practice of pouring medications into her and then into a cup from the . Class III	A 036		
A 054 SS=D	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.	A 054		

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A 054	Continued From page 7 (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] 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 [illegible], 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 maintain an updated medication observation record (MOR) for one out of six residents sampled who receive assistance with self-administration of medications (Residents #3). Findings included: Observation on /20206 at 710am showed Staff B assisted Resident # 3 with medications. Staff did not give Resident # 3 D 50,000UI. A review of the Medication order showed that D 50,000UI was once per week.	A 054		

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A 054	Continued From page 8 A review of Resident #3 MOR showed that D 50,000UI was annotated as given to Resident # 3 from to . A review of Resident # 3's D medication card showed that on and were punched out. Also, there were no other pills on the card except on and and the label read "1 vez a la semana" [Translation: once per week]. During an interview on /20206 at 7:14am Staff B stated that the annotation on the MOR were errors, and it was done "mechanically." A review of Staff B's records showed that she completed assistance with self-administration of medication training on . Class III	A 054		
A 078 SS=E	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual	A 078		

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A 078	Continued From page 9 basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or	A 078		

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A 078	Continued From page 10 more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff were properly trained in and First-Aid. Two out of three sampled staff (Staff B and C, caregivers) did not know how to render first aid to a choking victim. Findings included: During an interview on at 11:51am Staff C stated that she would raise a choking victim's up, when asked how she would render aid to someone choking. During an interview on at 12:12pm Staff B also stated that she would raise a choking victim up and , them on the , when asked how she would render aid to someone choking. Staff B stated that none of the residents had do not resistant order ( ), when asked who had a . According to the American Red Cross the proper way to render first aid on a chocking adult was to 1) Position self to the side and slightly behind the choking person; 2) Give 5 blows; 3) Use the heel of the to strike between the blades; 4) If no improvement, have the person stand up straight and move behind the person, bend your slightly for balance and support,	A 078		

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A 078	Continued From page 11 and Give 5 thrusts by Pulling inward and upward each time; 5) Continue giving 5 blows and 5 thrusts until the person can , cry or speak or becomes unresponsive; 6) If the person becomes unresponsive, lower them to a firm, flat surface and begin . A review of Staff B records showed that she completed her first aid training on . A review of Staff C records showed that she completed her first aid training on . Class III	A 078		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging	A 152		

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A 152	Continued From page 12 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, interview, and record review, the facility failed to provide a safe living environment. Findings included: Observation on at 6:25 am showed that in the kitchen under the sink there was unlocked cleaning detergent. Observation on at 6:26 am showed that in the kitchen there was a door that led into a makeshift pantry that was part of the garage. In the garage/pantry there were unlocked cleaning supplies. Observation on at 6:31 am showed that in the dining area there was a door that led into a makeshift staff room and laundry that was part of the garage. There was a laundry area in the room with unlocked cleaning detergents.	A 152		

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A 152	Continued From page 13 (photographic evidence obtained) Observation on at 7:00AM Resident #5 and #6 were walking about independently through the facility. A review of Resident # 6's records showed that he was diagnosed with , and other defects. A review of Resident # 5's records showed that he was diagnosed with major . During an interview on at 9:45 am the Administrator stated that Resident # 6 was his only resident under the limited mental health license. Class III	A 152		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff were trained in their duties and able to implement the emergency	A 182		

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A 182	Continued From page 14 management plan. Three out of three sampled staff (Administrator, Staff B and Staff C) was not trained and did not know how to implement the emergency environmental plan nor where residents should be evacuated to in the event of an emergency evacuation. Findings Included: During an interview on at 6:51am Staff B stated that the generator would power the whole house. When asked if there were cooling devices at the facility Staff B stated that there were lots of fans. During an interview on at 11:51am Staff C stated that she was trained in the facility emergency plans. When asked which places residents would be evacuated to in the event of a mandatory evacuation, Staff C did not know. During an interview on at 12:12pm Staff B stated that she was trained in the facility emergency plans. Staff B also did not know the places residents would be evacuated to in the event of a mandatory evacuation. A review of the mutual aid agreement showed two locations where resident could be evacuated to in the event of a mandatory evacuation. During an interview at 12:10pm the Administrator stated that the facility would be kept cool with portable air conditioning. During an interview at 12:11pm Staff B stated that there was no portable air conditioning at the facility for only fans. A review of the facility emergency environmental	A 182		

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	AL11968485	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISA HOME CORP	13316 SW 112TH CT MIAMI, FL 33176

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A 182	Continued From page 15 plan showed that the cooling spaces were going to be maintained cool with portable air conditioning. During an interview at 12:13pm the Administrator stated that he would need to update the plan. Class III	A 182		
AL241 SS=D	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 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	AL241		

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AL241	Continued From page 16 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 designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , , , as follows: a. An affirmative statement on the Alternate Care Certification for , , , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-03988, that the resident is receiving SSI or	AL241		

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AL241	Continued From page 17 SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 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	AL241		

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AL241	Continued From page 18 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 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	AL241		

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AL241	Continued From page 19 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 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	AL241		

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AL241	Continued From page 20 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. 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 records review and interview, the facility failed to clearly identify all residents undert the mental health component license in the admission and discharge log for one out of six sampled resident (Resident # 6) Findings included: A review of the facility records showed that the facility had a license for Limited Mental Health (LMH). A review of the facility's Admission and discharge log showed that none of the residents were	AL241		

Agency for Health Care Administration

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AL241	Continued From page 21 identified as mental health residents. A review of Resident # 6's records showed that he was diagnosed with , and other defects. During an interview on at 9:45am the Administrator stated that Resident # 6 was his only LMH resident, when asked who the mental health resident were. The Administrator stated that he did not know he needed to identify LMH resident in the admission and discharge log. Class III	AL241		