

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 R 04/06/2026
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} 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 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	{A 152}			

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 R 04/06/2026
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 1 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: An observation on _____ at 10:06 AM revealed unlocked cleaning equipment in the kitchen area. (photographic evidence obtained) In an interview on _____ at 10:07am, Staff E was asked was the cleaning supplies still unlocked in the kitchen area, Staff E stated, "Oh, I forgot those were there." Class III	{A 152}		
{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: Based on observation, and interview, the facility failed to ensure three out of eight sampled staff (Staff B, Staff D, and Staff F) were trained in their duties and were responsible for implementing the emergency management plan by being able to unlock the front main gate.	{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 R 04/06/2026
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 2 Findings: An observation on _____ at 6:16am revealed the facility was dark and the front gate bolted shut. Further observation revealed that after several minutes, Staff B, Staff D, and Staff F) (caregiver) came to the gate, then Staff B said that she had to find the key so that she could open it and was observed walking _____ into the facility. Staff B emerged several minutes later to unlock the gate. In an interview on _____ at 6:18am Staff D was asked why there was still a _____ lock at the front entrance, Staff D stated, "Well, we need to take care of that." 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	{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 R 04/06/2026
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 3 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 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	{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 R 04/06/2026
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 4 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 , , which is () 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 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	{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 R 04/06/2026
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 5 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 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	{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 R 04/06/2026
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 6 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 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	{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 R 04/06/2026
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 7 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. 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 implement a community living support	{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 R 04/06/2026
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 8 plan and _____ agreement for two out of 18 sampled residents (Resident #5 and Resident #12). Findings include: During an interview on _____ at approximately 10:25 AM with the Manager, she was informed that two residents did not have a community living support plan and _____ agreement, to which she stated, "They all have the agreement for this facility". A review of Resident #5's community living support plan and _____ agreement dated _____ revealed that it was completed for [] assisted living facility; the facility did not have its own plan. A review of Resident #12's community living support plan and _____ agreement dated _____ revealed that it was completed for [] assisted living facility; the facility did not have its own plan. Uncorrected Class III	{AL241}		
{A 000}	Initial Comments A revisit survey was conducted at Hialeah ALF Inc. on _____. Deficiencies were identified at the time of the survey.	{A 000}		
{A 052} SS=I	429.256(_____); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration 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 R 04/06/2026
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 9 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 the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include:	{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 R 04/06/2026
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 10 (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 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be 18	{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 R 04/06/2026
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 11 years of age 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 the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill	{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 R 04/06/2026
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 12 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 observations, interviews, and record review, the facility did not make sure that staff had followed the required procedures for assisting three of 18 sampled residents with taking their own medications (Residents #5, #12, and #16) . Findings Include: On at 6:54 AM, Staff D (Caregiver) was observed popping each medication from the pack into a cup. She told Resident #5 the name of each medication but did not state the dosage. On at 7:01 AM, Staff D was observed giving Resident #5 his . She did not state the name or dosage.	{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 R 04/06/2026
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 13 On at 7:07 AM, a review of the Medication Observation Record (MOR) for Resident #5 revealed that one medication was supposed to be given with food (within 30 minutes), and another was supposed to be given 15 to 30 minutes before a meal. On at 10:25 AM, during an interview regarding Staff D's medication pass, the Administrator asked, "Regarding Resident #5's , she does not tell them anything?". On at 7:09 AM, Staff D was observed completing a second medication pass with Resident #12, stating the medication name but not the dosage. She also wiped her hair with her gloved and continued the pass. On at 7:15 AM, Staff D was observed giving Resident #12 a liquid medication. The resident did not finish the full dose. On at 7:27 AM, Staff D was observed completing a medication pass with Resident #16. She confirmed his name and told him the name of the medication but did not state the dosage. Class II	{A 052}		
{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.	{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 R 04/06/2026
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 14 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 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;	{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 R 04/06/2026
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 15 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 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.	{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 R 04/06/2026
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 16 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep medications kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times. Findings included: Observation on _____ at 6:15 AM, revealed an container of "Thick-It" inside a unlocked cabinet of the kitchen . (Photographic evidence obtained) During an interview on _____ at 10:25 AM, concerning the unsecured medication, the Administrator acknowledged the findings. Class III	{A 055}		
{A 058} SS=D	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 R 04/06/2026
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 17 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 R 04/06/2026
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 058}	Continued From page 18 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 interview and record review the facility had one uncorrected Class II deficiency and one uncorrected Class III deficiency due to their medication practices. The facility also had one uncorrected Class II deficiency due to their failure to adhere to dietary standards. Findings include: 1) An observation on _____ at 6:54 AM revealed that during a medication pass, Staff D (Caregiver) did not inform Resident #5 of the dosage of his medication. Further observation revealed that she did not inform the resident of the medication name and dosage for his _____. An observation on _____ at 7:09 AM revealed that during a medication pass, Staff D did not inform Resident #12 of the dosage of his medication. An observation on _____ at 7:27 AM revealed that during a medication pass, Staff D did not inform Resident #16 of the dosage of his medication. During an interview on _____ at _____	{A 058}	
			(X5) COMPLETE 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 R 04/06/2026
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 19 approximately 10:25 AM with the Manager, she was asked for a report that contained updates to the corrective action plan from the licensed registered nurse that reflected what occurred during the visit to the facility, to which she stated, "A report? No, he doesn't do that". A review of the facility's deficiencies revealed that it previously obtained four Class II deficiencies for Medication: Assistance with Self-Administration, Medication: Labeling and Orders, Medication: Administration, Medication: Records on 2). An observation at 9:34 AM revealed that Staff F (Caregiver) and Staff G (Cook/Caregiver) provided Resident #4 with breakfast that contained cereal with milk and bread. During an interview on at approximately 10:25 AM with the Manager, she was informed that staff gave a resident that required a pureed diet, bread for breakfast. She stated, "Today we have cereal and bread, it's a soft toast but ok". A review of Resident #4's health assessment dated revealed that he required a pureed diet. A review of the facility's deficiencies revealed that it previously obtained one Class II deficiency for Food Services: Dietary Standards on Uncorrected Class III	{A 058}		