

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/11/2026
NAME OF PROVIDER OR SUPPLIER EBENEZER FAMILY HOME II, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1024 SW 11 STREET MIAMI, FL 33129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 000}	Initial Comments A revisit to a re-licensure survey was conducted at Ebenezer Family Home II, Inc. on Deficiencies were found to be uncorrected at the time of survey.	{A 000}			
{A 033} SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , or decline in mobility or function related to the use of the prescribed (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a physical care plan was complete for two out of six sampled residents (Resident #1 and Resident	{A 033}			

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: AL11968102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/11/2026
NAME OF PROVIDER OR SUPPLIER EBENEZER FAMILY HOME II, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1024 SW 11 STREET MIAMI, FL 33129		
(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 033}	Continued From page 1 #4). Findings include: An observation on _____ at 6:10 AM, revealed that Resident #1 and Resident #4 both had full bed rails equipped. During an interview on _____ at 7:57 AM with the Administrator, he was informed that the physical _____ care plans for Resident #1 and Resident #4 did not have the maximum amount of time that the physical _____ would need to be applied, he confirmed acknowledgement and asked "So, he [the physician] has to put the hours?". A review of Resident #1's physical _____ care plan dated _____ revealed that the "Maximum amount of time the resident is to have the _____ applied each day" was blank. A review of Resident #4's physical _____ care plan dated _____ revealed that the "Maximum amount of time the resident is to have the _____ applied each day" was blank. Uncorrected Class III	{A 033}			
{A 152} SS=E	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,	{A 152}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/11/2026
NAME OF PROVIDER OR SUPPLIER EBENEZER FAMILY HOME II, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1024 SW 11 STREET MIAMI, FL 33129		
(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 2 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 soiled. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that it maintained a safe living environment that was free of hazards for five out of six sampled residents (Residents #1, # 3, #4, #5 and #6). Findings include:	{A 152}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/11/2026
NAME OF PROVIDER OR SUPPLIER EBENEZER FAMILY HOME II, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1024 SW 11 STREET MIAMI, FL 33129		
(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 3 1). An observation on _____ at 6:06 AM revealed that there was what appeared to be _____ on the hallway floor that led down to the ramp of the lower level. An observation on _____ at 7:38 AM revealed that there was what appeared to be dried _____ still located on the ramp to the lower level. During an interview on _____ at approximately 7:57 AM, the Administrator was informed of the substance on the ramp, to which he stated, "The _____ is cleaned, it is not there anymore." 2). An observation on _____ at 6:12 AM revealed that there was a parrot located inside a cage in the staff room; there was also a [] brand injection pen located in the refrigerator. Further observation revealed that the door to the staff room was unlocked. During an interview on _____ at 6:12 AM, Staff B (Caregiver) was asked if the _____ in the refrigerator belonged to her, to which she confirmed. An observation on _____ at 6:46 AM revealed that the staff room door was still unlocked and accessible. During an interview on _____ at 7:21 AM, the Administrator was asked if he had a _____ policy for the parrot. To which he stated that he did not and that the parrot stayed outside.	{A 152}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/11/2026
NAME OF PROVIDER OR SUPPLIER EBENEZER FAMILY HOME II, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1024 SW 11 STREET MIAMI, FL 33129		
(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 4 During an interview on _____ at approximately 7:57 AM, the Administrator was informed about the medication in the unlocked staff room, to which he stated that the door was always locked. 3). An observation on _____ at 6:11 AM revealed that there was a rusted raised toilet seat located in the resident's bathroom. Uncorrected Class III	{A 152}			