

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 Complaint Investigation Survey (CCR # 2012011756) was conducted on Heavenly Home Care of Florida, Inc. Assisted Living Facility with a Limited Mental Health (LMH) component had the following deficiencies.	A 000		
A 030 SS=G	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) 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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96- _____ or 1(800)962-2873 " shall be posted in full view in a	A 030		

AHCA Form 3020-0001

TITLE

(X5) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0099

3H1411

If continuation sheet 1 of 29

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 1 common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical _____ shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 2 and can remove or avoid without assistance shall not be considered a physical 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, 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 achieve 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 3 provided in s. 429.27. (g) Share a _____ 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 at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care 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 shall be set forth in writing. 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, 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 4 active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide a safe and descent environment, free from _____ and neglect and failed to compensate resident(s) required to perform work in the facility. Findings Include: Record review of the facility staffing schedule posted at the facility, dated _____ 1-_____, 2012, revealed resident #1 was scheduled to work Monday thru Friday from 7 PM to 7 AM. In an interview with the administrator on _____ at approximately 3:44 PM, she stated resident #1 is no longer living at the facility. She stated he left in the end of _____ 2012. She stated he went to another facility. She stated he left because he wanted to be closer to his family. She stated that she was not told the name of the facility by him or his case manager. In an interview with staff #1 on _____ at approximately 3:45 PM, he stated resident #1 wanted to go back to the hood, he wanted to go back to the ghetto. In an interview with the administrator on _____ at approximately 4:01 PM, she stated that resident #1 would help out he did that. She stated he was very independent. She stated that he does not live here and does not work here		A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 5 {currently}. She stated she made the schedule from previous months. She stated it is not current. She stated he has done it before and she did not think it was a problem. She stated she would trust him to be put in charge. She stated that she lives here and is here all the time so they do not go by the schedule. She stated her or staff #1 is always here. She stated she does not really follow it. In an interview with the administrator on at approximately 4:06 PM, she stated that the residents could have overheard her and staff #1 arguing. In an interview with staff #1 on at approximately 4:15 PM, he stated tries to help the residents think and talk to them but not treat them like babies. He stated he wants them to get better. He stated he never touched a resident or cursed at a resident. Record review of resident #1's resident file revealed he was admitted to the facility on . Record review of resident #1's staffing file revealed he began employment at the facility on . In an interview with the administrator on at approximately 4:43 PM, she stated she added resident #1's name to the schedule because she felt like resident #1 was someone she can trust. In an interview with resident #1 on at approximately 4:46 PM, she stated she is treated fairly well at the facility. She stated that when the administrator's family comes, the administrator is mean but most of the time she is good. She stated she would tell her to "get her ass up." She stated that she says get your ass up most of the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 6 time. She stated she guesses she feels she needs her to do something. She stated the only thing they said that she doesn't like it to get her ass up. In an interview with resident #5 on _____ at approximately 4:54 PM, he stated that resident #1 used to sleep in the bed next to him. He stated he witnessed resident #1 and staff #1 arguing about drugs. He stated he has heard staff #1 curse at resident #1, worse. He stated he sometimes curses at him, but not too bad. He stated he has seen him curse at everybody, including resident #3. He stated no other staff members curse or yell at the residents. He stated that sometimes nobody is here just the residents. In an interview with resident #4 on _____ at approximately 5:04 PM, she stated she is sometimes treated with respect. She stated sometimes everyone laughs at her. She stated a few times staff #1 told her to behave when she was crying. She stated she does not remember if he has ever cursed at her or yelled at her. She stated she saw staff #1 yelling at resident #3. She stated she does not remember what he said though. She stated it happens when she acts strange. In an interview with resident #3 on _____ at approximately 5:21 PM, she stated that when they (staff) leave or they are off, resident #7 is in charge. She stated they leave resident #7 in charge quite a bit. She stated she is a good girl and washes the pots sometimes. She stated resident #7 is in charge on the weekend. In an interview with resident #7 on _____ at approximately 5:29 PM, she stated she has "never been _____ or cursed at but	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 7 maybe yelled at; you know." She stated she helps them out (staff) and has been left in charge. She stated they run to their parents' house and leave her in charge. She stated they go for a couple of hours. She stated it does not happen often. She stated on the weekends but it is fun. In an interview with the administrator on at approximately 5:33 PM, she stated that she will put resident #7 in charge when she walks around the . She stated she is very helpful. In email correspondence with the Field Office Manager of the Agency on at 11:06 AM, she stated the child of the administrator were removed from the facility due to domestic . In a phone interview with the administrator on at approximately 2:34 PM, she stated she had a prior history of domestic violence in 2010. She stated that resident #1 got into an argument with staff #1 because he took drugs out of his hands and that resident #1 grabbed in back. She stated that staff #1 would not allow resident #1 to bring drugs in the home. She stated after that happened they moved him. She stated she did not know what the substance was. She stated that resident #1 is like family and does not know why he did not call the cops because that would have been the best thing to do. She stated that resident #1 was upset because staff #1 took the drugs from him. She stated she did that it did not get too loud because no one was disturbed. She stated she may have overlooked telling me about this before. In a phone interview with resident #1 on at approximately 7:06 PM, he stated he had got pushed by the owner's baby's father. He stated he was there for five years. He stated he pushed	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 8 him and pushed this old lady. He stated she was sitting on the couch and he lifted it up and she ... and bumped her head. He stated her name is resident #3. He stated that she is scared of him. He stated his name is staff #1. He stated that he would start arguing and fighting over nothing. He stated he was watching the news at 5 in the morning so staff #1 cut off the electric. He stated staff #1 is a nasty person. He stated he cursed and "called him a pussy." He stated staff #1 would say he "would fuck everybody up." He stated staff #1 did not like his children in the environment and blamed us. He stated he had a daughter and a son. He stated that he was having problems with this guy and he was told by his case manager if he has a problem he has a right to leave. He stated they made an emergency move. He stated the place he is at now is a nice place. He stated staff #1 found drugs in his . He stated he was not messing with marijuana or anything like that. He stated all of this was before that. He stated that staff #1 was in jail. He stated he cursed and had an attitude and he would not look at him. He stated that they {staff} started leaving and putting him in charge but he did not want any of that. He stated every week and during the weekend they leave the residents alone. He stated at first it was whatever but then they stopped all of that and did not get people their : checks. He stated that they did not pay him for being in charge. He stated they did not give any money to anybody. He stated they went out and be gone for hours. He stated that the people were sleeping by the time they came back. He stated he thinks staff #1 had a problem with him because of where he is from. He stated they had this guy come over and they told me not to go to the program and he talked to him about the rules and all of that. He stated they signed it and the training's lasted about a good two hours.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 9 He stated when he signed the paper he did not know what was going on. He stated he never told them that he did not want to do it. He stated he was afraid not to tell them because they get mad over everything. He stated he would rather live in peace then get them mad but it didn't work he had to move. He stated staff #1 also beats up the administrator. In a phone interview with the administrator on _____ at approximately 9:11 AM, she acknowledged the findings and stated she does not think resident #7 is certified and _____ and First Aid. She inquired if resident #7 took the class and was willing to, if the fine would be removed. She stated resident #1 completed _____ and First Aid and will fax for verification. She stated she only left resident #7 in charge when she goes outside to play with her children or walk the neighborhood. She stated she did not compensate her. She stated resident #1 never worked at the facility but when he was left in charge she would give him \$20.00 dollars.	A 030			
A 032 SS=G	Class II 58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 032	Continued From page 10 residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with _____ and related _____ assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident's family/caregiver. (b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include: 1. An immediate staff search of the facility and premises; 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities; 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility		A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157			
(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 032	Continued From page 11 shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the assisted living facility failed to follow proper facility resident elopement policies and procedures for 1 out of 7 (resident #2) sampled residents. Findings Include: In an interview with the administrator on _____ at approximately 3:40 PM, she stated she did not add resident #2 to the admission and discharge log because she was only at the facility for a day. In an interview with staff #1 on _____ at approximately 3:34 PM, he stated it is because of the crazy girl that just left here. Staff #1 walked out stating amazing, amazing, amazing. In an interview with the administrator on _____ at approximately 3:35 PM, she stated now that she is thinking it could be resident #2. She stated she came in Thursday and left Thursday night. In an interview with the administrator on _____ at approximately 4:06 PM, she stated she knows what this is about. She stated resident #2 came from Jackson from the Crisis unit and the first day she was pleasant and by the second night she was screaming and having hallucinations and making threats and saying they are going to kill her and woke up the house. When she had her episode, she asked to use the phone and said the residents were taking her stuff and staff #1 was talking to her and telling her certain things. She stated she called her brother Jake, she does not even know if it was her brother and she stated	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 032	Continued From page 12 she needed to leave right away and she left. She stated the case manager did not answer the phone. In an interview with staff #1 on _____ at approximately 4:15 PM, he stated that he called the police in regards to resident #2 and when he did she took some stuff and left. He stated he does not know where she left to. In an interview with the administrator on _____ at approximately 4:24 PM, she stated that she called the family of resident #2 and called her case manager from jail diversion. She stated that she wanted to leave. She stated the aunt stated that she would contact the guy and she did not sound too concerned. She stated the father was called and apologized and stated to call the mother. She stated she took her medications with her. She stated that they did not call the police because they would say she wanted to leave and it is not a missing persons. Record review of resident #2's file revealed she had discharge paperwork from Jackson Memorial Hospital and a health assessment which was not dated. Record review of the health assessment revealed resident #2 was diagnosed with " _____ and _____ Type," and needs medication supervision. In an interview with the administrator on _____ at approximately 4:36 PM, she stated that resident #2 was admitted on last week Wednesday on the 12th { _____ }. In a phone interview with the aunt of resident #2 on _____ at approximately 11:31 AM, she stated the facility did call and told her that resident #2 left the house but she has no idea	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 032	Continued From page 13 where she is. She stated that she usually checks in with her but she has not. She stated she needs to be put somewhere where she cannot leave when she gets angry. She stated she has done this in the past. She stated she needs to be put somewhere where they can take care of her. In a phone interview with the case manager of resident #2 on _____ at approximately 3:23 PM, he stated that the facility notified both him and the family. He stated that resident #2 is still missing. He stated they are trying to engage her in other treatment but she denies any type of treatment. He stated that she could be in harm because she has not taking her medications but she is not a harm to herself but can be a harm to others. He stated she gets a little aggressive when she stops taking the medications. He stated she has had altercations with her family but not strangers. He stated that she can get confrontation if approached though. He stated he was not able to get in touch with the person she left with because they do not have that person 's information. He stated that the facility should have notified the police of missing persons. He stated she was coherent enough to know what she was doing. He stated it is possible that her symptoms increased because of a new environment but she had been taking medications up to that point. In a phone interview with the administrator on _____ at approximately 3:57 PM, she stated she got in touch with resident #2's case manager from the Jail Diversion program. She stated he just took the information and the day that she left and said he would follow up. She stated she will definitely call in a missing persons report (upon request) and fax it over to me.	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 032	Continued From page 14 In a phone interview with the case manager of resident #2 on _____ at approximately 4:02 PM, he stated resident #2 was _____ and he was able to get her out of jail and link her to treatment but she had issues with compliance and did not follow up with what she was supposed to do. It was a misdemeanor case and the judge decided to close the case and she continued to refuse treatment. He stated that she was in Jackson Memorial because she was picked up by police and was _____. He stated the placement was done through the hospital. She had been with their program for a few months now. He stated this is her first facility. He stated she has a history of leaving her family but always returned to sleep. He stated the family has a very sporadic schedule so we are unable to verify if she has returned home or not. He stated she is very _____ and during visits she has _____ events and not receptive of people coming to her home. Record review of the fax received from the facility showing that the facility filed a missing persons report when notified that resident #2 is a possible harm to others when not on her medications. Case #PD121220483411. In a phone interview with the case manager of resident #2 on _____ at approximately 3:57 PM, he stated he conducted a home visit today and the client was there. He stated they could not engage her because they did not want to talk to them. He stated they could not engage her in treatment. He stated that she left her medications at the facility and did not take it with her. He stated that he never told the facility that they will try and find her. He stated sometimes if they end up being _____ they will notify them. He stated that the facility left a message because he was	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 032	Continued From page 15 out of the office for the weekend. He stated he got the message until Monday and it was left on Thursday. He stated he called them back when he got the message. He stated that he told them he would look for her. He stated he never said that he took care of it. He stated the facility stated he left with family and they notified the father. He stated he only has contact with the aunt and mother. He stated he did not fill out a missing persons report because it happened at the facility they are responsible for it. He stated the facility waited four days for him to call him back. He stated they should have notified someone if they have not got a hold of anybody here. In a phone interview with the administrator on _____ at approximately 2:34 PM, she stated that resident #2 was brought on Monday from Jackson Memorial Crisis Unit and they stated that they had her there and she called the police back and told them where they can find her. She stated she did not know when she was brought or why she was brought to the hospital. She stated they told her that she was a bit _____. She stated they were ready to discharge her again. She stated she would not accept her back anymore. In a phone interview with the administrator on _____ at approximately 9:11 AM, she acknowledged the findings and stated she does not believe she could have done anything because resident #2 left on her own. Class II		A 032		
A 052 SS=D	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH		A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 16 SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least _____, trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record. (d) 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 which coincides with the resident's presence in the facility; 2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 17 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; (e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. (f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition. (4) Assistance with self-administration 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 through intermittent positive pressure breathing machines or a _____. (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of _____ preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) _____, _____, or _____ preparations. (h) Medications ordered by the physician or health care professional with prescriptive		A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 18 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 at the request of a competent resident. (i) 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. This Statute or Rule is not met as evidenced by: Based on observation and interview the administrator did not follow appropriate procedure in assisting residents with self-administration of medication for 1 out of 5 (resident #3) current residents. Findings Include: Observations on ... at approximately 5:27 PM found all five residents sitting at the dining ... Observations found the administrator brought over medications for resident #3. Observations found the administrator the administrator made sure resident #3 had water but failed to read the label in the presence of the resident. Observations found the administrator did not wait for resident #3 to take her medications before proceeding back into the kitchen. In an interview with both the administrator and staff #1 on ... at approximately 5:36 PM, when notified, the administrator acknowledged the findings and staff #1 stated, "you have to do that?" Class III		A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED																						
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157																								
(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 SS=	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: <table border="1"> <thead> <tr> <th>Number of Residents</th> <th>Staff Hours/Week</th> </tr> </thead> <tbody> <tr><td>0-5</td><td>168</td></tr> <tr><td>6-15</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 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within 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 facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night. 4. At least one staff member who is trained in First Aid and _____, as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility. 5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least _____, must be designated in writing to be in charge of the facility. 6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall	Number of Residents	Staff Hours/Week	0-5	168	6-15	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	Staff Hours/Week																									
0-5	168																									
6-15	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: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 20 not be counted toward meeting the minimum staffing hours requirement. 7. The administrator or manager 's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility 's staffing schedule. 8. 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, shall 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 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident 's care. (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to 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 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The		A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 21 Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and 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, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. 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 Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (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 Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively.	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 22 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that staffing standards were met. Findings Include: Observations on _____ at approximately 3:31 PM found the administrator arrived to the facility in her vehicle. Observations on _____ at approximately 3:44 PM found only the administrator and staff #1 at the facility upon entrance. Record review of the facility staffing schedule posted at the facility, dated _____ 1- _____, 2012, revealed resident #1 was scheduled to work Monday thru Friday from 7 PM to 7 AM. Record revealed revealed staff #2 was scheduled to work on Tuesdays' from 7 AM - 7 PM { _____ out on a Tuesday}. In an interview with the administrator on at approximately 3:44 PM, she stated resident #1 is no longer living at the facility. She stated he left in the end of _____ 2012. She stated he went to another facility. She stated he left because he wanted to be closer to his family. She stated that she was not told the name of the facility by him or his case manager. In an interview with the administrator on at approximately 4:01 PM, she stated that resident #1 would help out he did that. She stated he was very independent. She stated that he does not live here and does not work here (currently). She stated she made the schedule from previous months. She stated it is not current. She stated he has done it before and she		A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 23 did not think it was a problem. She stated she would trust him to be put in charge. She stated that she lives here and is here all the time so they do not go by the schedule. She stated her or staff #1 is always here. She stated she does not really follow it. Record review of resident #1's resident file revealed he was admitted to the facility on Record review of resident #1's staffing file revealed he began employment at the facility on In an interview with resident #5 on at approximately 4:54 PM, he stated that sometimes nobody is here just the residents. In an interview with resident #3 on at approximately 5:21 PM, she stated that when they (staff) leave or they are off, resident #7 is in charge. She stated they leave resident #7 in charge quite a bit. She stated she is a good girl and washes the pots sometimes. She stated resident #7 is in charge on the weekend. In an interview with resident #7 on at approximately 5:29 PM, she stated she helps them out (staff) and has been left in charge. She stated they run to their parents' house and leave her in charge. She stated they go for a couple of hours. She stated it does not happen often. She stated on the weekends but it is fun. In an interview with the administrator on at approximately 5:33 PM, she stated that she will put resident #7 in charge when she walks around the She stated she is very helpful. In a phone interview with resident #1 on at approximately 7:06 PM, he stated that they	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 24 (staff) started leaving and putting him in charge but he did not want any of that. He stated every week and during the weekend they leave the residents alone. He stated at first it was whatever but then they stopped all of that and did not get people their checks. He stated that they did not pay him for being in charge. He stated they did not give any money to anybody. He stated they went out and be gone for hours. He stated that the people were sleeping by the time they came back. He stated they had this guy come over and they told me not to go to the program and he talked to him about the rules and all of that. He stated they signed it and the training's lasted about a good two hours. He stated when he signed the paper he did not know what was going on. He stated he never told them that he did not want to do it. He stated he was afraid not to tell them because they get mad over everything. He stated he would rather live in peace then get them mad but it didn't work he had to move. In a phone interview with the administrator on _____ at approximately 9:11 AM, she acknowledged the findings and stated she does not think resident #7 is certified and _____ and First Aid. She inquired if resident #7 took the class and was willing to, if the fine would be removed. She stated resident #1 completed and First Aid and will fax for verification. She stated she only left resident #7 in charge when she goes outside to play with her children or walk the neighborhood. She stated she did not compensate her. She stated resident #1 never worked at the facility but when he was left in charge she would give him \$20.00 dollars. Class II	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility's license which shall be 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 place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure _____; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is _____, the date of Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (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) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 26 provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C. (j) 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. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 27 to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years. (n) 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. (o) 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. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility's resident elopement response policies and procedures. (r) The facility's documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on record review and an interview the assisted living facility failed to maintain an accurate admission and discharge log. Findings Include: Record review of the facility's admission and discharge log revealed resident #2 was not on the admission and discharge log, resident #1 was admitted on _____ but not discharged, and resident #4 was admitted on _____ and discharged on _____. Record review revealed resident #4 did not have an additional entry and resident #1 was a current resident.	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HEAVENLY HOME CARE OF FLORIDA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 17321 SW 109 AVENUE MIAMI, FL 33157		
(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 28 In an interview with the administrator on at approximately 3:40 PM, she stated she did not add resident #2 to the admission and discharge log because she was only living at the facility for a day. In an interview with the administrator on at approximately 3:44 PM, she stated resident #1 no longer lives at the facility. She stated he left in the end of She stated resident #4 moved back to the facility at the end of . Class III	A 160			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Heavenly Home Care Of Florida, Inc
17321 Sw 109 Avenue
Miami, FL 33157

Re: CCR #2012011756

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

