STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966038	01/18/2018
NAME OF PROVIDER OR SUPPLIER **CARING FAMILY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **650 SW 60 COURT** **MIAMI, FL 33144**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A complaint inspection was conducted from . . . . through . . . . (CCR # 2018000355). Caring Family Corp, License # 10307, had the followng deficiencies identified at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to adequately provide care and services appropriate to meet the needs of the residents by not properly assessing, monitoring or supervising and did not promote safety and physical well-being to 4 out of 6 at-risk residents (Residents # 1, #2, #3, and #4).

Findings Include:

On . . . . , a revisit inspection was attempted at the facility. The surveyor found that the facility's gate was closed, with a real-estate lock on the main door. Phone interview on at 9:51 AM Staff A stated, "the ALF is closed, and I transferred the residents that I had. I want to surrender my license but I spoke to my consultant and she told me to think before I do it. I transferred the residents because I did not have enough residents to cover the expenses."

On . . . . at 10:30 AM, Staff A called the field office to say that she had closed the facility. She stated that two residents had gone to the hospital and the other two went to live with family. The residents did not receive 45 days' notice and she was not going to close the facility, just didn't have any residents.

On . . . . Staff A called the field office again and said she was worried all weekend about the situation with the facility. Staff A stated that she had been sick and an employee, who worked for her, Staff B had taken the residents. Staff A reported the last time she had seen the residents was before Christmas ( ). Staff A didn't know how long the residents had been gone, or where they were. Staff A also didn't know how many residents had been living there, and didn't know what any of the residents' names. Staff A reported that all of the resident records and employee files had also been taken, including her own record. Even the refrigerator had been taken. When asked, Staff A said that a police report had not been filed and reported that Staff B wouldn't tell her where the residents were.

Phone interview on , at 10:25 AM Staff B reported Staff B stopped working with the facility in . . . . . , and that there were no residents there. Stated that she took one resident to Facility B: Resident #2. Later Staff B stated that she also took Resident #1 to Facility B.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Staff A and Staff B were unable to provide an accurate list of residents who were living at the facility. According to records from the Agency's last inspection in , there were six residents living there (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6).

Resident #1, , diagnosed with , type II, , and .

Resident #2, , diagnosed with , Incontinence.

Resident #3, , diagnosed with , Parkinson's, , and .

Resident #4, , diagnosed with , Hypolipoproteinemia, and .

Resident #5, , on . the facility did not have a record for the resident included a completed health assessments, doctor's orders, progress notes, and a completed demographic sheet.

Resident #6, . the facility did not have a record for the resident included a completed health assessments, doctor's orders, progress notes, and a completed demographic sheet.

During a visit to Facility Bon Staff B reported Staff B transferred four residents from the facility to her facilities. Resident #4 was transferred to Facility C on , and Resident #3 was transferred to Apostolado #3 on . Resident #5 , . Resident #6 only was at the facility for two days and is currently living with his son. Staff B also reported that Staff B helped Staff A manage the facility for three years. Staff A informed Staff B that she did not need to give a 45 days' notice to the residents because the residents wanted to be transferred to another ALF.

During the visit at Facility Bon Resident #1 and Resident #2 were interviewed at 10:26 AM. Resident #2 stated said she lived in another ALF before but she did not remember why she was transferred to this facility. And Resident #1 stated that she lived in Cuba and she has been coming here since she was a little girl.

Office meeting conducted with Staff A and Staff B on at 2:00 PM. They stated that it was a

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	AL11966038	01/18/2018
NAME OF PROVIDER OR SUPPLIER **CARING FAMILY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **650 SW 60 COURT** **MIAMI, FL 33144**	

SUMMARY STATEMENT OF DEFICIENCIES
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misunderstanding, and that the resident records were at the facility. Staff B reported that Staff B did not need to give the residents 45 days' notices because the families said it was ok to move them. Staff B further reported that two of the residents did not have any family and had given their own consent. Staff B reported there were four residents at the time that the facility closed: Resident #3 went to Apostolado #3, gave consent. Resident #4 went to Facility C and family gave consent. Resident #2's brother was called and gave consent for her to be taken to Facility B. Resident #1's daughter in law was called and approved the move. The facility or staff members could not provide the Agency proof of a power of attorney or guardianship documentation that allowed the family members to make decisions for the residents.

The facility was visited on at 10:00 AM. The facility did not have any residents on the premises. Resident record of Resident #1, Resident #2, Resident #3, and Resident #4 were reviewed. The facility did not have a record for Resident #5, who , , on and Resident #6, whose admission and discharge dates are unknown. Staff A was unable to provide the names of the residents that resided in the facility. Staff A reported that Staff B managed the facility with her consent. Staff B provided the copies of 45 days' notices allegedly given to the residents on . When asked Staff B reported that 45 days' notices were not given to the residents. Staff B further stated that the 45 days' notices were given, and Staff A and Staff B signed the forms. Staff B was listed as the administrator.

During a Monitoring visit to FacilityD on . Resident #3 was observed in bed with a half bed rail raised. The staff stated that the resident was able to transfer with assistance , however she was not observed getting out of bed during the monitoring visit. She did not know how long she had been at the facility and that she didn't know where her identification or other papers were.

During a Monitoring visit to Facility C on , the caregiver stated that Resident #4 had a nephew who was her POA. He and his wife usually visited weekly but there had been an illness and other issues in the family, so they had missed a few visits. She said she had spoken with the nephew since Resident #4 had been transferred back to Facility C when he called looking for his aunt, since he had not been informed that she was moved.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview, the Administrator failed to treat four of six sampled residents with

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	AL11966038	**01/18/2018**
NAME OF PROVIDER OR SUPPLIER **CARING FAMILY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **650 SW 60 COURT MIAMI, FL 33144**	

SUMMARY STATEMENT OF DEFICIENCIES
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dignity and respect, and failed to provide 45 days' notice that the residents were required to move (Residents #1-4). Staff B closed the facility and transferred the residents to Staff B's facilities without knowledge of Staff A and without the residents' or family members' consent.

Findings Include:

On Staff A called the field office again and said she was worried all weekend about the situation with the facility. Staff A stated that she had been sick and an employee, who worked for her, Staff B had taken the residents. Staff A reported the last time she had seen the residents was before Christmas ( ). Staff A didn't know how long the residents had been gone, or where they were. Staff A also didn't know how many residents had been living there, and didn't know what any of the residents' names. Staff A reported that all of the resident records and employee files had also been taken, including her own record. Even the refrigerator had been taken. When asked, Staff A said that a police report had not been filed and reported that Staff B wouldn't tell her where the residents were.

Phone interview on , at 10:25 AM Staff B reported Staff B stopped working with the facility in , and that there were no residents there. Stated that she took one resident to Facility B: Resident #2. Later Staff B stated that she also took Resident #1 to Facility B.

Staff A and Staff B were unable to provide an accurate list of residents who were living at the facility. According to records from the Agency's last inspection in , there were six residents living there (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6).

Resident #1, , diagnosed with , type II, , , , , and .
Resident #2, , diagnosed with , Incontinence.
Resident #3, , diagnosed with , , Parkinson's, , and .
Resident #4, , diagnosed with , Hypolipoproteinemia, , , , , , and , .
Resident #5, . , on . the facility did not have a record for the resident included a completed health assessments, doctor's orders, progress notes, and a completed demographic sheet.
Resident #6, . the facility did not have a record for the resident included a completed health assessments, doctor's orders, progress notes, and a completed demographic sheet.

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SUMMARY STATEMENT OF DEFICIENCIES
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During a visit to Facility B on . Staff B reported Staff B transferred four residents from the facility to her facilities. Resident #4 was transferred to Facility C on , and Resident #3 was transferred toFacility D on . Resident #5-, . Resident #6 only was at the facility for two days and is currently living with his son. Staff A told her that Staff A would close the facility and she needed to transfer all the residents. Staff A informed Staff B that she did not need to give a 45 days' notice to the residents because the residents wanted to be transferred to another ALF.

During the visit at Facility B on Resident #1 and Resident #2 were interviewed at 10:26 AM. Resident #2 stated said she lived in another ALF before but she did not remember why she was transferred to this facility. And Resident #1 stated that she lived in Cuba and she has been coming here since she was a little girl.

Office meeting conducted with Staff A and Staff B on at 2:00 PM. They stated that it was a misunderstanding, and that the resident records were at the facility. Staff B reported that Staff B did not need to give the residents 45 days' notices because the families said it was ok to move them. Staff B further reported that two of the residents did not have any family and had given their own consent. Staff B reported there were four residents at the time that the facility closed: Resident #3 went to Facility D, gave consent. Resident #4 went to Facility C and family gave consent. Resident #2's brother was called and gave consent for her to be taken to Facility B. Resident #1's daughter in law was called and approved the move. The facility or staff members could not provide the Agency proof of a power of attorney or guardianship documentation that allowed the family members to make decisions for the residents.

The facility was visited on at 10:00 AM. The facility did not have any residents on the premises. Resident record of Resident #1, Resident #2, Resident #3, and Resident #4 were reviewed. The facility did not have a record for Resident #5, who , on and Resident #6, whose admission and discharge dates are unknown. Staff A was unable to provide the names of the residents that resided in the facility. Staff A reported that Staff B managed the facility with her consent. Staff B provided the copies of 45 days' notices allegedly given to the residents on . When asked Staff B reported that 45 days' notices were not given to the residents. Staff B further stated that the 45 days' notices were given, and Staff A and Staff B signed the forms. Staff B was listed as the administrator.

During a Monitoring visit to Facility D on . Resident #3 was observed in bed with a half bed rail raised. The staff stated that the resident was able to transfer with assistance, however she was not observed getting out of bed during the monitoring visit. She did not know how long she had been at the

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	AL11966038	**01/18/2018**
NAME OF PROVIDER OR SUPPLIER **CARING FAMILY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **650 SW 60 COURT** **MIAMI, FL 33144**	

SUMMARY STATEMENT OF DEFICIENCIES
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facility and that she didn't know where her identification or other papers were.

During a Monitoring visit to Facility C on , the caregiver stated that Resident #4 had a nephew who was her POA. He and his wife usually visited weekly but there had been an illness and other issues in the family, so they had missed a few visits. She said she had spoken with the nephew since Resident #4 had been transferred back to Facility C when he called looking for his aunt, since he had not been informed that she was moved.

Class II

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the Administrator failed to oversee the operation and management of the facility to prevent the systemic breakdown of facility's operations which led to four residents be taken to other locations without their consent. The Administrator failed to demonstrate that she was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents, and assigned the operation of the facility to Staff B, who already operated three assisted iving facilities (ALF).

Findings Include:

Staff A abdicated her position as the Administrator to Staff B at The facility. Staff B was listed as the Administrator of three other ALFs which included Facility B, Facility C, and Facility D. An administrator may supervise only a maximum of three ALFs. Staff B closed the facility and transferred the residents to Staff B's facilities without knowledge of Staff A and without the residents' or family members consent.

On . . . . . , a revisit inspection was attempted at the facility. The surveyor found that the facility's gate was closed, with a real-estate lock on the main door. Phone interview on . . . . . at 9:51 AM Staff A stated, "the ALF is closed, and I transferred the residents that I had. I want to surrender my license but I spoke to my consultant and she told me to think before I do it. I transferred the residents because I did not have enough residents to cover the expenses."

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On . . . . . Staff A called the field office again and said she was worried all weekend about the situation

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SUMMARY STATEMENT OF DEFICIENCIES
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NAME OF PROVIDER OR SUPPLIER **CARING FAMILY CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **650 SW 60 COURT** **MIAMI, FL 33144**	

SUMMARY STATEMENT OF DEFICIENCIES
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Class II