Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967124	A. BUILDING: _____ B. WING _____	R 08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUNI ALF	370 NW 133RD PLACE MIAMI, FL 33182

(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
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to maintain an up-to-date employee roster in the background screening database. Findings included:	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ814	Continued From page 1 On . . . . . at 9:28 AM, Staff E was cleaning in the facility. On further at 10:30 AM, Staff E was observed in the facility providing services to the residents. A review of Florida Health finder database showed Staff A was listed as facility's Administrator. Personnel records review revealed Staff D was hired on . . . . . and Staff E was hired on . Review of the background screening database showed Staff B , D and E were listed. Staff D was listed as "Administrator" hired on , Staff B was hired on . . . . . , and Staff E was hired on and terminated on . On at 10:22 AM, Staff A stated the facility hired a new administrator, but they did not send the change of administrator form to the agency, and Staff B had not been working in the facility for fifteen days. 	CZ814		
CZ816 SS=C	408.809(2)(a-c); 59A-35.090(2)(d)-(3) Background Screening-Compliance Attestation 408.809 (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or	CZ816		

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CZ816	Continued From page 2	CZ816		

contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [illegible] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [illegible] are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the [illegible] of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with [illegible], the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement

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CZ816	Continued From page 3 community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 59A-35.090(2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively	CZ816		

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CZ816	Continued From page 4 licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an updated level II background screening for one out of five sampled staff (Staff E) that had a break in service of more than 90 days. The facility failed to maintain an attestation of compliance form in the personnel records for two out of five (Staff D and E) sampled staff. Findings included: Observation on at 9:28 AM, showed Staff E was caring for and providing personal services to the residents. Personnel records review revealed Staff E hired	CZ816		

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CZ816	Continued From page 5 on . . . . . had an eligible level II background screening completed on . Staff D (hired on . . . . .) and E did not have the attestation of compliance form in their files. Background screening clearinghouse database review showed Staff E last employment was from . to . On at 10:30 AM, Staff E stated that she had not worked in an ALF for a long time. On . . . . . at 11:10 AM, Administrator confirmed that Staff D and E did not have the attestation of compliance form in their files. Unclassified	CZ816		
CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes	CZ824		

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CZ824	Continued From page 6	CZ824		

permission for an appropriate inspection to verify the information submitted on or in connection with the application.
(a) All inspections shall be unannounced, except as specified in s. 408.806.
(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules.
(2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification.
(3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an offsite review.
(4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency.
(5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required.
(6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made

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CZ824	Continued From page 7 confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection. 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the	CZ824		

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CZ824	Continued From page 8 beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to correct deficiencies within 30 calendar days after being notified of inspection results. Findings included: Staffing Standards- Administrators- The facility failed to have an Administrator who completed the required training and education, including the competency test, within 90 days after date of employment as an administrator during the Change of Ownership (CHOW) survey conducted on . The facility still did not have an Administrator who passed the CORE competency test during by the first revisit to the CHOW survey conducted on and concluded on , the second revisit to the CHOW survey conducted on and concluded on and during the during third revisit to the CHOW from to . Resident Rights- During the second (CHOW) inspection conducted on and concluded	CZ824		

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CZ824	Continued From page 9 on . . . . . , the facility failed to have a doctor's order for the use of bed rails as physical . . . . During the during third revisit to the CHOW from . . . . . to . . . . . , the facility failed to have doctor order for the use of bed rails as physical . . . . . as well as to have consent from the resident or residents' representative for the use of bed rails. Records- Facility - During the second (CHOW) inspection conducted on . . . . . and concluded on . . . . . , the facility failed to to proof of a satisfactory annual fire inspection. During the during third revisit to the CHOW from . . . . . to . . . . . , the facility failed to have an up-to-date admission and discharge log with accurate information. Unclassified	CZ824		

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{A 000}	Initial Comments A third revisit to a change of ownership survey in conjunction with a second revisit to complaint investigation (complaint number 201900125) and a complaint investigation (complaint number 2019011805) was conducted at Zuni Alf on . . . . . and concluded on . . . . . . Deficiencies were identified at the time of survey.	{A 000}		
A 031 SS=D	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services 58A-5.0182 (7) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) If residents accept assistance from the facility	A 031		

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A 031	Continued From page 1 in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. 429.255 (1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that third party services had been provided to meet resident's needs for one out of six (Resident #2) sampled residents. Findings included: Review of Resident #2's record showed she was admitted to the facility on and was diagnosed with arrythmia, Poly ( ), , and . The health assessment document she required medication administration.	A 031		

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A 031	Continued From page 2 Resident's #2 hospice record review showed she was admitted on . . . . . The record document the physician ordered , 500 mg, one tablet daily, for seven days on . . . . . . Medication reconciliation showed that there was no documentation that the resident received the medication. Interview conducted on . . . . . at 1:00 PM, Administrator stated that the last time the physician ordered . . . . . to the resident was on , . During the exit conference conducted on . . . . . at 12:30 PM, Administrator stated she forgot that hospice ordered . . . . . to the resident, few days before she was sent to the hospital. Administrator said the resident received the medication, but she was unable to find the documentation (MOR) to show that the resident received the medication. In addition, she said the facility staff assisted the resident with her medications. Class III	A 031		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.	A 054		

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A 054	Continued From page 3 (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to document the assigned schedule time in Medication Observation Records (MORs) for assisting three out of six sampled residents with self-administration of medication (#6, #5, #4 and #3). The facility failed to immediately update the MORs when the residents take the medications for one out of sampled residents (#5).The facility failed to ensure that MORs included any known [illegible], the name of the resident's health care provider, the health care provider's telephone number, and the period of time for charting for one out of six sampled residents (#4). The facility also failed to ensure that MORs included any known [illegible] the resident may have for one out of six sampled residents (#3).	A 054		

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(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 054	Continued From page 4 Findings included: On at 9:28 AM, Staff C opened the facility's main door and she was on duty Staff E. On at 9:35 AM, observed one room next to living room and # . The room was the space for storing residents' medications. The medication storage area was open. There was a medication card with pills on it. The medication card was labeled with Resident #4's name and the medication was 15 mg tab. It had instructions of taking one tablet for daily with food and discontinued 100 mg. There was a closet inside that storage for the four residents' medications. The closet was not secured and had medications for Residents #3, #5, #6, and #4. On further observation at 9:43 AM, the medication room remained opened. Review of Resident #6's MORs showed that the medications did not have scheduled time; the MORs showed "AM" and "PM". There was an order of Triple to apply in the affected area daily effective . Staff did not initial the medication in the MORs. There was an order of 20% to apply in the affected area daily. Staff did not initial the medication in the MORs. There was an order of SSD 1% cream to apply daily in the affected area. Staff did not initial the medication in the MORs. Review of Resident #4's MORs showed that the medications did not have scheduled time; the MORs showed "AM" and "PM". The MORs did not show any known the resident may have, the name of the resident's health care provider, the health care provider's telephone	A 054		

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	AL11967124	A. BUILDING: _____ B. WING _____	R 08/19/2019

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A 054	Continued From page 5 number, and the period of time for the month of . Review of Resident #5's MORs showed that the scheduled time for the morning medications (25 mg tablet, 75 mg tablet, Sod 10 mg tablet, 5 mg tablet, DN 10 mg tablet, 20 mg tablet, and 15 mg tablet) was at 8 AM. There was an order of IcyHot cream relieving to apply for relief. Staff did not initial the medication in the MORs. There was an order of NYSTOP 100,000 units/gm powder to apply in the affected area daily. Staff did not initial the medication in the MORs. The scheduled time for 10 gm/15 ml solution, MAPAP 325 mg tablet, and , 15 mg tablet showed "AM" and "PM". Review of Resident #3's MORs showed that the scheduled time for the morning medications was at 8 AM except for mg tablet and Centrum Silver Supplement tablet. The and the Centrum did not have scheduled time; the MORs showed "AM" and "PM". The section was blank. Review of Resident #3's record showed that the resident had an to sulfa on the demographic data collected in the demographic sheet. The health assessment showed an to Sulfa and . On at 10:06 AM, Staff C revealed that the medication room had a key and that this room remained closed at all the time. She said the medication room was open because she just signed the MOR. On at 11:25 AM, Staff A revealed that	A 054		

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A 054	Continued From page 6 the residents took the morning medications with breakfast at around 8 AM, the noon medications at around 2 PM, and the night medications between 7 PM and 8 PM. On further interview at 12:11 PM, she added that Resident #5's daughter brought the medication, referring to IcyHot cream , reliever, and that the resident asked for it when she needed it. Staff A stated she believed that the powder for Resident #5 was discontinued because her got worse with that treatment. Class III	A 054		
A 055 SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;	A 055		

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A 055	Continued From page 7 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued	A 055		

Agency for Health Care Administration

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A 055	Continued From page 8 medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep medications secured at all times. Findings included: On . . . . . at 9:34 AM, there was a room next to the living room where three out four residents in the facility sat. The room's door was opened and Residents #4 and #5 sat in the living room next to the staff's room. There were two bottles with medication next to the window in the staff room. The medications bottles were for Centrum and , PM. On at 9:34 AM, Staff C identified the	A 055		

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A 055	Continued From page 9 room next to the living room with the door opened as the staff room. She revealed that the staff room was used as staff room and office. The unsecured bottles of medications belonged to her. On . . . . . at 9:35 AM, there was another room next to living room and to # . The room was the space for storage Residents' medications. The medication storage area was opened. There was a medication . . . . card with pills on it. The medication card was labeled with Resident #4's name and the medication was 15 mg tab. It had instructions of taking one tablet for , daily with food and discontinued . . . . . 100 mg. There was a closet inside that storage the four residents' medications. The closet was not secured and had medications for Residents #3, #5, #6, and #4. On . . . . . at 9:36 AM, Resident #6 rested on bed in # with full bed rails up. On at 9:43 AM, the medication room remained opened. On . . . . . at 9:48 AM, there was a medication bowl labeled with Resident #5's name in # on the nightstand. The medicine showed in the label 20% and to apply on the affected area daily. On . . . . . at 10:06 AM, Staff C revealed that the medication room had a key and that room remained closed at all the time. The medication room was opened because she just signed the MORs (Medication Observation Records). Class III	A 055		

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A 056	Continued From page 10	A 056		
A 056 SS=D	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

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A 056	Continued From page 11 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056		

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A 056	Continued From page 12 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to contact the health care provider for requesting revised instructions about the appropriate circumstances the resident to request the medication and specified limitations for one out of six sampled residents (#3). Findings included: Review of Resident #3's Medication Observation Records (MORs) showed that there was an order of , mg tablet to take one tablet for , as needed. The staff signed MORs at "AM" and "PM" since to and in the AM on . On at 12:09 PM, Staff A revealed that there was no documentation indicating that the resident needed the medication around the clock for his , . She said the resident asked for the medication. Class III	A 056		
{A 077} SS=C	429.176 FS; 429.52( ),58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner	{A 077}		

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{A 077}	Continued From page 13 changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52( ), FS (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections	{A 077}		

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{A 077}	Continued From page 14 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before , are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise	{A 077}		

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{A 077}	Continued From page 15	{A 077}		

more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.
(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility.
(e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to be under the supervision of an administrator who ensured the

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{A 077}	Continued From page 16 management of all staff and the provision of appropriate care to all residents. The administrator failed to ensure that residents had qualified and trained staff to provide resident care and meet the residents' needs for four out of six sampled residents (#3, #4, #5 and #6). The facility failed to be under the supervision of an administrator who completed core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Findings included: On . . . . . at 9:28 AM, ovserved were two staff on duty Staff C and E. Further observed that Staff E was cleaning and here were residents in the living room. On further observation at 10:30 AM, Staff E was observed providing services to the residents. Personnel record review revealed that Staff E was hired on . . . . . . The results level II of background screening check showed that she was eligible on . . . . . . There was no evidence that Staff E completed the attestation of compliance with background screening requirements. Review of the background screening database showed that Staff E hired date was on and with termination date on . . . . . . The background screening clearinghouse database showed Staff E last employment was from to . On . . . . . at 10:30 AM, Staff E revealed that she did not work in ALF for a long time. On . . . . . at 11:10 AM, Staff A confirmed that Staff E did not have the attestation of compliance form in their files.	{A 077}		

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{A 077}	Continued From page 17 Review of Resident #3's record showed that the admission date was on . The demographic data collected in the demographic sheet showed that the resident had to sulfa. The health assessment (AHCA form 1823) indicated that the resident had to Sulfa and , the medical history and diagnoses included and needed assistance with self-administration of medication. Review of Resident #3's MORs showed that the scheduled time for the morning medications was at 8 AM except for mg tablet and Centrum Silver Supplement tablet. The and the Centrum did not have scheduled time; the MORs showed "AM" and "PM". The section was blank. Resident #3's discharge summary from the hospital showed that the resident had acute reaction on . Resident #3's discharge summary from the hospital showed that the resident had a flank on . The discharge summary indicated follow up in 2 days with the primary care physician and with the urologist. Review of Resident #3's record showed on the progress notes that on the resident did not feel well. He complained of lower and area. The facility contacted the primary care physician's office, spoke the one of the assistant who revealed that she will return the call. On at 2:10 AM, the resident returned to the facility; the facility contacted the primary care physician's office and forward emergency report. On at 12:03 PM, Staff A revealed that on Resident #3 had intermittent . She did not recall exactly if Resident #3 went to the	{A 077}		

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	AL11967124	A. BUILDING: _____ B. WING _____	R 08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUNI ALF	370 NW 133RD PLACE MIAMI, FL 33182

(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 077}	Continued From page 18 hospital that date. On . . . . . at 9:34 AM, there was a room next to the living room where three out four residents in the facility sat. The room's door was opened and Residents #4 and #5 sat in the living room next to the staff's room. There were two bottles with medication next to the window in the staff room. The medications bottles were for Centrum and , PM. On at 9:34 AM, Staff C identified the room next to the living room with the door opened as the staff room. She revealed that the staff room was used as staff room and office. The unsecured bottles of medications belonged to her. On at 9:35 AM, there was another room next to living room and to # . The room was the space for storage Residents' medications. The medication storage area was opened. There was a medication card with pills on it. The medication . . . card was labeled with Resident #4's name and the medication was . . . . . 15 mg tab. It had instructions of taking one tablet for , daily with food and discontinued . . . . . 100 mg. There was a closet inside that storage the four residents' medications. The closet was not secured and had medications for Residents #3, #5, #6, and #4. On . . . . . at 9:36 AM, Resident #6 rested on bed in # with full bed rails up. On . . . . . at 9:43 AM, the medication room remained opened. On . . . . . at 9:48 AM, there was a medication bowl labeled with Resident #5's name in # on the nightstand. The medicine showed in the label 20% and to apply on the affected area daily.	{A 077}		

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{A 077}	Continued From page 19 On at 10:23 AM, Staff A revealed that Resident #2 was the only one that had a { } but she . The rest of the residents did not have ( ). On at 10:27 AM, the Staff A opened Resident #5's hospice record and stated, "Oh, look she has a ". Review of Resident #5's hospice record showed that there was a signed on . 2. Review of Florida Health Finder revealed that the facility appointed Staff A as the administrator. Review of Background Screening Clearinghouse database showed that the facility's administrator was Staff A. Review of Staff A's personnel record showed the hired date on . She completed the CORE training on . Staff took the CORE test on , did not pass the test and had a new test , , on at 8:30 AM. On at 10:07 AM, Staff A arrived to the facility. She identified herself as the facility's owner. She revealed that Staff D was the new administrator for the facility effective . Staff D was assigned as the new administrator and the change was submitted to Tallahassee. On at 10:20 AM, the facility's consultant was contacted via telephone. She revealed that was out on vacations and stated, "I am going to send the change of administrator today." On at 10:22 AM, Staff A revealed that she was aware that the facility did not submit the change of administrator to Tallahassee. Staff A stated that she did not pass the CORE administrator's certification test and that she had	{A 077}		

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{A 077}	Continued From page 20 an [illegible] for taking the test on [illegible]. Uncorrected Class III	{A 077}		
A 079 SS=D	58A-5.019(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 [illegible] 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 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in 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	A 079		

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A 079	Continued From page 21 facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 58A-5.0191(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all	A 079		

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A 079	Continued From page 22 aspects of resident care, and is listed on the facility's staffing schedule. 9. 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, must 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 that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must 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 agency will consult with the facility administrator and residents regarding any determination that additional staff is required. 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 rule chapter 69A-40, F.A.C., until such time as the local fire	A 079		

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A 079	Continued From page 23 safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to 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, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (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 rules 58A-5.029, 58A-5.030 or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to enough staff for meeting the residents' scheduled and unscheduled needs for one out of six sampled residents (#2). Findings included: Review of Resident #2's progress notes in the record showed that the resident started feeling bad on in the afternoon. The resident	A 079		

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A 079	Continued From page 24 was dizzied, had . . . . . and . . . . . The facility called the nurse from hospice and the rescue. The rescue (emergency medical services) transferred the resident to the hospital. On at 11:47 AM, Staff C revealed that Resident #2 rested on bed and asked the staff for going to the bathroom. The resident was able to walk with walker and some assistance to the bathroom. She sat in the toilet and she changed her . . . . . brief. The resident was unable to get out of the toilet when she attempted to do it. The fainted while she getting up from the toilet. The staff put her in the bed and called the administrator (Staff A) using her own cellular phone. The staff called Resident #3 who called the emergency services. Resident #2 was alert and oriented all the time. Resident #3 brought the phone to the staff who talked to the operator from emergency services. The rescue transferred Resident #2 to the hospital; the nurse from hospice arrived when the resident was in the ambulance. Review of facility's admission and discharge log showed that Residents #2, #3, #5, and #6 lived in the facility on . . . . . . Residents #2, #5 and #6 received hospice services. Review of Resident #2's hospice assessment completed on . . . . . showed that she had functional Review of Resident #5's record showed in the health assessment that that the resident needed total care for all activities of daily living (ambulation, bathing, ... , eating, self-care, toileting and transferring). The resident was	A 079		

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A 079	Continued From page 25 identified with precautions. Review of Resident #6's record showed in the health assessment that the resident needed assistance with all activities of daily living (ambulation, bathing, , eating, self-care, toileting and transferring). The resident was identified with precautions. Reviewed of hospice record showed that the resident was admitted to Heartland on with the diagnoses of 's with late onset, essential , , and mixed . Plan of care cover to . Review of the facility's staffing pattern for week of thru , showed that on Staff A was on call, Staff B worked from 7 PM- 6 AM, Staff C worked from 7 AM-7 PM and Staff E worked from 7 AM-2 PM. The week from thru 10th, 2019 showed that Staff A worked from " .", Staff C worked from 7 AM-7 PM, Staff D worked from " :30" and Staff E worked from 6:30 AM-2 PM. On at 10:04 AM, Staff C revealed that Staff E worked from 6:30 AM to 2 PM but she worked alone after 3 PM. On at 11:15 AM, Staff A revealed that Staff B stopped working in the facility more than 15 day earlier. Staff A further stated that Staff B did not work on when Resident #2 was transferred to the hospital. Class III	A 079		

Agency for Health Care Administration

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A 152	Continued From page 26	A 152		
A 152 SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, [redacted] 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	A 152		

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A 152	Continued From page 27 be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order. Findings included: On . . . . . at 9:32 AM, . . # 's bathroom had a broken tile in the shower. The bathroom did not have enough light. The bathroom lamp needed four light bulbs but just one out of four light bulbs worked. The shower floor's corners had a greenish/brownish color between the tiles. The ceiling had brownish/yellowish stains . . . # , which housed two residents, did not have enough light; there was one floor lamp with two yellow bulbs. On at 9:44 AM, there was one bathroom in the hallway close to . . . # . . # . The bathroom had two broken tiles on the step for entering to the shower. The shower floor's corners had a greenish/brownish color between the tiles. The ceiling had some peeling paint above the shower. On at 9:44 AM, Staff C revealed that the shower drainage had problems. Class III	A 152		
{A 160} SS=D	58A-5.024(1) FAC Records - Facility The facility must maintain required records in a	{A 160}		

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{A 160}	Continued From page 28 manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license 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 facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 58A-5.025, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (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) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 58A-5.026, F.A.C., that must	{A 160}		

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{A 160}	Continued From page 29	{A 160}		

be readily available by facility staff.
(e) The facility's liability insurance policy required in Rule 58A-5.021, F.A.C.;
(f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.
(g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0181, F.A.C.
(h) If the facility advertises that it provides special care for persons with [redacted] or related [redacted], a copy of all such facility advertisements as required by Section 429.177, F.S.
(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.
(j) All food service records required in Rule 58A-5.020, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate.
(k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last 2 years.
(l) 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.
(m) 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.
(n) The facility's resident elopement response

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{A 160}	Continued From page 30 policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an up-to-date admission and discharge log with accurate information. Findings included: On at 9:28 AM, Residents #5, #4 and #3 were in the living room. Resident #4 sat in a chair with his closed. Resident #5 sat watching TV and Resident #3 stood up and ambulated with the walker to his room. Review of the facility's admission and discharge log showed that the entrance in the record for Resident #4 did not indicate an admission date. The log showed that Resident #4's discharge date was on . It did not indicate the reason for discharge or identification of the facility or home address to which the resident was discharged. Resident #6's admission date to the facility was on but it did not indicate the facility or place from which the resident was admitted. Resident #1's discharge date was on because she moved with her daughter to her family house. The log did not show the home address to which the resident was discharged. On at 12:16 PM, Staff A revealed that	{A 160}		

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ZUNI ALF	370 NW 133RD PLACE MIAMI, FL 33182

(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 31 Resident #6 came from her house and that Resident #4 was not discharged from the facility. The date indicated in the admission and discharge log as discharge date for Resident #4 was the actual admission date to the facility. Class III	{A 160}		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020,	A 162		

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A 162	Continued From page 32 F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at:	A 162		

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A 162	Continued From page 33 http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a	A 162		

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A 162	Continued From page 34 resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a complete health assessment for three out of six sampled residents (#2, #3 and #5). The facility failed to accurate health assessment for two out of six sampled residents (#5 and #4). The facility failed to have a current the interdisciplinary care plan for a resident receiving hospice services for one out of six sampled residents (#5). The facility also failed to have a consent for the use of bed rails for two out of sampled residents (#5 and #6). The facility failed to obtain a doctor order for the use of bed rail for one out of sampled residents (#6). Findings included: 1. Record review showed Resident #2's health assessment (date not provided) did not specify the type of assistance the resident needed with the activities of daily living. Interview conducted at 12:30 PM, Administrator confirmed Resident #2's health assessment was incomplete. Review of Resident #3's record showed that the admission date to the facility was on . . . . There was a health assessment (AHCA form	A 162		

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A 162	Continued From page 35 1823) on record and it did not have documented the date of examination. Review of Resident #5's record showed that the admission date to the facility was . . . . . There was one Health Assessment (AHCA form 1823) in the record and it did not have documented the resident's . . or the date of examination. The assessment showed that the resident needed medication administration and needed total care for all Activities of Daily Living (ADL) (ambulation, bathing, ..., eating, self-care, toileting and transferring). On . . . . . at 11 AM, Resident #5 revealed that the staff helped her with her medications but she was able to take her medications by herself as well as to eat by herself. She used her walker for ambulation and the staff helped her. On . . . . . at 11:12 AM, Staff A revealed that Resident #5 ate independently and the staff assisted with her medication. She received supervision or assistance as needed with the rest of the ADLs. The resident received theassistance of one or two staff for ambulating plus she used the walker or wheelchair. Review of Resident #4's record showed on the demographic data collected in the demographic sheet showed that the resident had . . . . to seafood and . The health assessment (AHCA form 1823) with date of completion on and revision on showed "NKDA" (No Known Drug . . . .). Review of Resident #5's hospice record showed that she started to receive hospice services on . . . . . The hospice diagnoses included degenerative of the nervous system,	A 162		

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A 162	Continued From page 36	A 162		

essential , , and unspecified without behavioral disturbance. The hospice plan of care on record covered the certification period from to .

2.

On at 9:36 AM, Resident #6 rested on bed in # with full bed rails up.

On at 9:48 AM, Resident #5's bed had a half-bed rail attached.

Review of Resident #5's hospice record showed that there was a doctor order signed on for side rails up in order to avoid .

Review of Resident #5's record revealed that there was no consent to the use of bed rail.

Review of Resident #6's hospice record showed that there was a verbal doctor's order signed by a Registered Nurse on at 12:00 PM for full rails.

Review of Resident #6's record revealed that there was no consent to the use of bed rail.

On at 10:26 AM, Staff A revealed that she was not able to find the consent for the use of bed rails. On further interview at 10:37 AM, Staff A stated, "It looks that the consent was not part of the package....yes, it is not here, the consent for the bed rails."

Class III

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CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to maintain an up-to-date employee roster in the background screening database. Findings included:	CZ814		

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CZ814	Continued From page 1 On . . . . . at 9:28 AM, Staff E was cleaning in the facility. On further at 10:30 AM, Staff E was observed in the facility providing services to the residents. A review of Florida Health finder database showed Staff A was listed as facility's Administrator. Personnel records review revealed Staff D was hired on . . . . . and Staff E was hired on . Review of the background screening database showed Staff B , D and E were listed. Staff D was listed as "Administrator" hired on , Staff B was hired on . . . . . , and Staff E was hired on and terminated on . On at 10:22 AM, Staff A stated the facility hired a new administrator, but they did not send the change of administrator form to the agency, and Staff B had not been working in the facility for fifteen days. Unclassified	CZ814		
CZ816 SS=C	408.809(2)(a-c); 59A-35.090(2)(d)-(3) Background Screening-Compliance Attestation 408.809 (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or	CZ816		

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CZ816	Continued From page 2 contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [illegible] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [illegible] are enrolled in the Federal Bureau of Investation's national retained print notification program. If the [illegible] of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with [illegible], the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement	CZ816		

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CZ816	Continued From page 3 community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 59A-35.090(2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively	CZ816		

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CZ816	Continued From page 4 licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an updated level II background screening for one out of five sampled staff (Staff E) that had a break in service of more than 90 days. The facility failed to maintain an attestation of compliance form in the personnel records for two out of five (Staff D and E) sampled staff. Findings included: Observation on at 9:28 AM, showed Staff E was caring for and providing personal services to the residents. Personnel records review revealed Staff E hired	CZ816		

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CZ816	Continued From page 5 on . . . . . had an eligible level II background screening completed on . Staff D (hired on . . . . .) and E did not have the attestation of compliance form in their files. Background screening clearinghouse database review showed Staff E last employment was from . to . On at 10:30 AM, Staff E stated that she had not worked in an ALF for a long time. On . . . . . at 11:10 AM, Administrator confirmed that Staff D and E did not have the attestation of compliance form in their files. Unclassified	CZ816		
CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes	CZ824		

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CZ824	Continued From page 6	CZ824		

permission for an appropriate inspection to verify the information submitted on or in connection with the application.
(a) All inspections shall be unannounced, except as specified in s. 408.806.
(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules.
(2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification.
(3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an offsite review.
(4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency.
(5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required.
(6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made

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CZ824	Continued From page 7 confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection. 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the	CZ824		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967124	A. BUILDING: _____ B. WING _____	R 08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUNI ALF	370 NW 133RD PLACE MIAMI, FL 33182

(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
CZ824	Continued From page 8 beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to correct deficiencies within 30 calendar days after being notified of inspection results. Findings included: Staffing Standards- Administrators- The facility failed to have an Administrator who completed the required training and education, including the competency test, within 90 days after date of employment as an administrator during the Change of Ownership (CHOW) survey conducted on . The facility still did not have an Administrator who passed the CORE competency test during by the first revisit to the CHOW survey conducted on and concluded on , the second revisit to the CHOW survey conducted on and concluded on and during the during third revisit to the CHOW from to . Resident Rights- During the second (CHOW) inspection conducted on and concluded	CZ824		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CZ824	Continued From page 9 on . . . . . , the facility failed to have a doctor's order for the use of bed rails as physical . . . . During the during third revisit to the CHOW from . . . . . to . . . . . , the facility failed to have doctor order for the use of bed rails as physical . . . . . as well as to have consent from the resident or residents' representative for the use of bed rails. Records- Facility - During the second (CHOW) inspection conducted on . . . . . and concluded on . . . . . , the facility failed to to proof of a satisfactory annual fire inspection. During the during third revisit to the CHOW from . . . . . to . . . . . , the facility failed to have an up-to-date admission and discharge log with accurate information. Unclassified	CZ824		