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
	AL11966208	A. BUILDING: _____ B. WING _____	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUD'S PLACE	860 NW 186 DR MIAMI, FL 33169

(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
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person 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. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; 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 interview and record review, the facility failed to maintain an updated staff roster in the background screening clearinghouse for one out of five sampled staff (Staff D) was not listed. Findings included: Record review of the facility Employee Sign-in revealed Staff D had been working at the facility since . Review of the facility Clearinghouse database showed Staff D was not listed there as an employee. On at 11:45 AM the Administrator stated, " I thought I added Staff D. Unclassified	ZZ814		

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A 000	Initial Comments A Complaint (2025009867) survey was conducted at Maud's Place on . The provider had deficiencies identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.	A 025		

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being of one out of three sampled residents (Resident #1). Resident #1 eloped from the facility and was found 15 days later. Findings included: A review of the adverse incident report filed on showed, "On On Saturday, , around 11:00 AM Resident #1 left the facility. Staff B who was working noticed Resident #1 had not returned and notified the Administrator	A 025		

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A 025	Continued From page 2 about three to four hours later. A review of Resident #1's progress notes showed documentation of multiple times of when the resident left the facility after eloping. In an interview on at 9 AM, Resident #1's stated I just wanted to leave." And could not recall when or how he got to the facility. A review of the facility's elopement policy showed "Elopement is described as leaving the facility property beyond perimeter of the parking lot or further; he or she is missing more than 24 hours; leaves without the facility's knowledge have not verbally informed the facility staff of their plans for returning to the facility." A review of Resident #1's record showed no documentation that the facility contacted the resident's physician about the resident's desire to leave or if they sought guidance on preventing the occurrence from happening numerous times. Review of the health assessment revealed the facility failed to have an updated health assessment completed for Resident #1. The health assessment found completed was dated showed. Resident #1 Medical history and Diagnoses: ; major numerological , essential tremors, and , . There were no physical or sensory limitations. The or behavioral/ status: decline. The nursing/ treatment/ , service requirements: routine. The special precautions showed none. Resident #1 was independent with ambulation and eating. He requires assistance with bathing, , self-care (grooming), toileting, and transferring and needed assistance with self-administration.	A 025		

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A 025	Continued From page 3 He was not a risk for elopement. Class II	A 025		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo	A 032		

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A 032	Continued From page 4 identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assess residents who showed signs of elopement for one out of the five sampled residents (Resident #1), who left the facility without staff knowing his whereabouts. The resident was not reassessed after he eloped on . Facility failed to have Resident #1 reassessed by a physician after eloping from the facility. The facility failed to follow its policies and procedures regarding elopement when one out of	A 032		

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A 032	Continued From page 5 three sampled residents (Resident #1) eloped from the facility. The facility failed to have three out of five (Resident #1) assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. Findings included: A review of the adverse incident report submitted by the facility documented on showed that Resident #1 left the facility without the facility knowledge. After a search by the Administrator, law enforcement was called. Record review showed Resident #1 elopement risk assessments was not completed at time of admission. Review of the health assessment revealed the facility failed to have an updated health assessment completed for Resident #1. The health assessment found completed was dated showed -Medical history and Diagnoses: ; major numerological , essential tremors, and . There were no physical or sensory limitations. - or behavioral/ status: decline -Nursing/ treatment/ service requirements: routine -Special precautions: none -Elopement risk: no Resident #1 was independent with ambulation and eating. He requires assistance with bathing, , self-care (grooming), toileting, and transferring and needed assistance with self-administration. Record review revealed the last elopement drill	A 032		

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A 032	Continued From page 6 was conducted on . Review of the progress notes revealed on , , , and Resident #1's had left the facility and demonstrated signs of prior to eloping on . On at 9:15 AM Resident #1 was interviewed and stated, "I left because I did not want to stay here." On at 8:40 am with Staff C when asked if there were any elopement risk residents in the facility. Staff C stated that Resident #1 was not an elopement risk. Staff C stated that "Resident #1 every now and then he wanted to leave, and he is a big man, and I cannot hold him. He gets upset and he leaves and goes out and then he comes . I always call the Administrator, and she would talk to him and sometimes he would calm down. Sometimes he would leave because he is upset and then he would go to the [Hospital]." When asked what intervention had they put in place to prevent any residents from leaving the facility and eloping? On at 8:45 AM Staff C stated, "I had a meeting and have to make sure every resident sign out on the log before leaving, and we had a meeting about Resident #1 leaving what we should do. We already know what to do if there is an elopement and to make sure to call the Administrator immediately." On at 9:20 AM the Administrator stated, "Staff B no longer works here she moved out of the country. That day she said he wanted to go out. He was saying he was bored and he left. When she noticed it was almost nighttime, he	A 032		

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A 032	Continued From page 7 hadn't come . That's when we started looking for him. On at 9:35 AM Administrator stated, "When he left here, he was admitted to a hospital and when he was discharged, he went to [Hospital] and they contacted us to let us know he was there, and I went to pick him up. I found out later he went to a friend's house. I ended up contacting his ex-girlfriend who said he did not come to see her. That he had gone to a friend's house. The friend had called her the night prior. That friend stated he (Resident #1) walked to his house. The friend said when he got there, he was sweaty, he was coughing, and he did not look good. I had him clean up and I was just finishing dinner, and I fed him. He couldn't stay here so I gave him five dollars, and he left. When I talked to the friend it had not been 24 hours yet. When I didn't see him and that's when I put in the missing person report with the police. They told me they would be on the lookout for him. Sometimes he goes through these maniac phases where he wants to go out. Someday's Resident #1 listens and someday's he won't. He's left before and has come . He left and he'll go to the [hospital]. I did not have him evaluated for elopement. No, I did not have a new health assessment completed for him since he came . When asked what protocols were put in place to avoid residents eloping and staff training. The Administrator stated, "I have the staff to make sure each resident sign in and out on log that's it and the length of time I need to be notified." Class II	A 032		

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A 079	Continued From page 8	A 079		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

(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
	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 59A-36.015(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 facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there

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A 079	Continued From page 9 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 ( ) 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 59A-36.011(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 . 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 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 aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079		

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A 079	Continued From page 10 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 59A-36.007, 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 59A-36.007, 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 safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the	A 079		

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A 079	Continued From page 11 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 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations, record review and interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for five out five (Staff A, B, C, D, and E) sampled staff a given time period. Findings included: Review of the facility records revealed no staffing schedule posted. There was no schedule available for review of hours worked for the daily and for the week.	A 079		

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
	AL11966208	A. BUILDING: _____ B. WING _____	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUD'S PLACE	860 NW 186 DR MIAMI, FL 33169

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A 079	Continued From page 12 On at 8:35 AM Staff C was asked for the staff schedule and stated, "We do not have one. I just sign in when I work on the sign in sheet. Review of the sign-in sheet revealed the days Staff C, D, and E sign in for their shifts In an interview on at 10:15 AM the Administrator confirmed there was no schedule posted and stated, "I will send it to the staff in a chat." Class III	A 079		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable:	A 161		

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A 161	Continued From page 13 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ˬ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide an employment application with references and documentation for background screening for one out of five (Staff D) sampled staff. Findings included:	A 161		

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A 161	Continued From page 14 Record review of the Administrator's personnel record revealed she had no application with references and no background screening paperwork in file. The background screening database showed the Staff D was hired 11/28/24. In an interview on at 9:15 Staff C stated, "Staff D worked on the weekend Saturday and Sunday.": In an interview on at 12:35 PM the Administrator confirmed Staff D does not have a background screening on file. In an interview on 09//24/25 at 12:37 PM the Administrator confirmed Staff D did not have an application because "I had her redo it because it was not correct." Class III	A 161		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse	A 165		

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A 165	Continued From page 15 incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and	A 165		

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A 165	Continued From page 16 Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to file an initial adverse incident report within one business day after one out of three	A 165		

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A 165	Continued From page 17 (Resident #1) sampled residents had eloped from the facility where law enforcement had been contacted. Findings included: A review of Resident #1's record showed the resident was admitted to the facility on . A review of the online Adverse Incident Reporting System (AIRS) database showed Resident #1 had eloped from the facility on and that the one-day report was filed two days later on On at 11:30 AM, the Administrator stated Resident #1 left the facility on and that the staff had not let her know until six hours later. She had searched for him outside and the places the facility he frequented and did not find him. She notified the police. On at 12:30 PM The Administrator acknowledged that she did not file an adverse incident report. Class III	A 165		