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
	AL11964818	A. BUILDING: _____ B. WING _____	R 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE POINT HOME CARE INC	21910 SW 97 COURT CUTLER BAY, FL 33190

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit survey was conducted at Blue Point Home Care Inc. on . The provider had deficiencies at the time of the survey.	{A 000}		
A 025 SS=D	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		

AHCA Form 3020-0001

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

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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 observation, record review and interview, the facility failed to ensure one out of six sampled residents received personal supervision as appropriate, including daily observation by designated staff, of the activities of the resident while on the premises, and awareness of the general health. Findings: Observation on at 8:55 AM Resident #1 alone to eat in room without assistance or supervision and some of the cereal remained around his . A review of Resident #1's health assessment	A 025		

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A 025	Continued From page 2 dated showed the resident needed assistance in eating. Interviewed on at 10:03 AM during the exit conference, the Administrator acknowledged the deficiency. Class III	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his	A 052		

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A 052	Continued From page 3 or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , ,. converting, or ,. medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or , preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

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A 052	Continued From page 4 administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	A 052		

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A 052	Continued From page 5 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) offered one (Resident #5) out of six sampled residents their medications at the	A 052		

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A 052	Continued From page 6 prescribed time by the health care provider. The facility failed to ensure Staff B observe Resident #5 take the prescribed medications. Findings: Observation on at 8:16 AM showed Staff B offered Resident #5's medications: Hipp 1 MG, , 2.5 MG, 0.5 MG, 20 MG, 325 MG, , 3 MG, 5 MG, Probiotic Acidophilus Bead, and 50 MG prescribed for 7:00 AM and signed the medication observation record before observing the resident take the medications. Interviewed on at 10:03 AM the Administrator stated that the staff gave the medications at 7:57 AM and she would review the camera. The Administrator stated further that the Agency (for Health Care Administration)'s staff was the reason Staff B gave the medications late. However, the Administrator did not arrive in the facility until 8:33 AM, and there were two employees including Staff B in the facility at the time of the medication pass. A review of Staff B's personnel records showed six hours of assistance with self-administration of medication training on . Class III	A 052		
{A 078} SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement	{A 078}		

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{A 078}	Continued From page 7 from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule	{A 078}		

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{A 078}	Continued From page 8 chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure one (Staff B Caregiver) out of three sampled employees was capable in describing , , ( ) techniques consistent with their level of education, training, preparation, and experience. The facility failed to ensure Staff B obtain three (3) hours in activities of daily living and behavioral needs training. Findings: Observation on at 7:52 AM Staff B was working in the facility. Interviewed on at 9:47 AM when asked to describe what she would do with a	{A 078}		

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{A 078}	Continued From page 9 choking victim, Staff B stated that she would , the person on their and then push the person. When asked to describe techniques and how she would know someone need , Staff B stated that she would lay the person on the floor and call 911. Staff B did not explain or describe the next steps. A review of Staff B's personnel records found training dated . However, there were no activities of daily living and behavioral needs trainings. Interviewed on at 8:33 AM the Administrator stated that Staff B was new and she (Staff B) did not have all the training. Interviewed on at 10:03 AM during the exit conference, the Administrator stated that the employee did not understand in Spanish. A review of data from the American Red Cross showed, "Check for breathing and the carotid , for at least five seconds not more than 10 secods. If the patient is unresponsive, isn't breathing normally and doesn't have a , , begin . Move the patient to the floor or ground. Provide 30 , and two breaths." A review of data from Cleveland Clinic showed, when dealing with a choking victim: "stand to the side and getbehind the person. Kneel if it's a small child. Lean the person slightly forward, use your nondominant to gently support the person's . This means if you're right handed, use your left for support. Use the heel of your dominant to strike the area between their blades. This is called a blow or slap, Do up to five of these. Between	{A 078}		

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{A 078}	Continued From page 10 each one, pause to see if the object has come out. If five blows aren't enough, do up to five adnominal thrusts. This is also called [thrust]. You make a fist with one and clasp your other around it. Place your between the person's belly button and cage and push inward and upward. Don't attempt this unless you're trained. If the person is still choking, repeat this sequence of five blows and five thrust until the object comes out or medical help arrives. It the person goes at any point before help arrives, begin . if you are able." Class III	{A 078}		
A 093 SS=G	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_ Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the	A 093		

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A 093	Continued From page 11 residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food	A 093		

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A 093	Continued From page 12 choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for	A 093		

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A 093	Continued From page 13 obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow a puree diet as prescribed by the health care provider for one (Resident #1) out of six sampled residents. The facility's Administrator failed to perform duties in a safe and sanitary manner with some expired emergency foods. Findings: Observation on at 7:57 AM Resident #1 in hospital bed eating a bowl of cereal with chunks of banana in it. Photographic evidence obtained. Observation on at 8:55 AM Resident #1 eating cereal with bananas in it was found coughing and milk running down at both corners of his . Interviewed on at 10:03 AM during the exit conference, the Administrator acknowledged that the bananas in the cereal were not pureed. A review of Resident #1's records found no waiver or notes to opt out of a therapeutic diet. A review of the facility's posted puree menu showed assorted juices, cooked soft cereal, soft poached egg, margarine, milk and coffee or tea. A review of Resident #1's health assessment dated showed diagnoses of , essential , .	A 093		

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	AL11964818	A. BUILDING: _____ B. WING _____	R 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE POINT HOME CARE INC	21910 SW 97 COURT CUTLER BAY, FL 33190

(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 093	Continued From page 14 , , hyperplasia, , , right , , , and . . The physical status showed bedbound. The status showed awake, alert, and oriented to name and place and forgetful. The nursing status showed hospice care services. The resident needed assistance with eating and was total care with bathing, , self-care, transferring and toileting. The special diet instructions showed puree. Observation on at 8:05 AM found some of the emergency food supplies with expiration dates to include: 1 box cereal (.) , 1 can classic chicken noodle , 2 boxes Cheez It . According to the International , , Diet Standardization Initiative, states: "puree diet is usually eaten with a spoon and do not require chewing. Have a smooth texture with no lumps. Hold shape of spoon. off a spoon in a single spoonful when tilted. Are not sticky. Pureed food may be used if you are not able to bite or chew food if your control is reduced. Pureed foods only need the to be able to move forward and to bring the food to the of the for swallowing. It is important that pureed foods are not too sticky because this can cause the food to stick to the cheeks, roof of or in the . Pureed foods are best eaten using a spoon." Class II	A 093		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:	A 162		

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A 162	Continued From page 15 (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 resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, 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 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), 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. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in	A 162		

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A 162	Continued From page 16 writing that ◡ not be taken. (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 59A-36.006, 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 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, 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: 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	A 162		

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A 162	Continued From page 17 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 59A-36.006, 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 a log listing the names of residents participating in this arrangement. (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 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 59A-36.020, 59A-36.021 and 59A-36.022, 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 maintain an accurate health assessment for one (Resident #2) out of six sampled residents. Findings: Observation on at 7:55 AM Staff C	A 162		

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A 162	Continued From page 18 (Caregiver) totally spoon fed Resident #2 cereal. A review of Resident #2's health assessment dated showed the resident needed assistance in eating, ambulation, bathing, self-care, toileting and transferring. Interviewed on at 10:03 AM during the exit conference, the Administrator acknowledged. Class III	A 162		