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
	AL11963986	A. BUILDING: _____ B. WING _____	R 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIALEAH ALF INC	158 WEST 8 STREET HIALEAH, FL 33010

(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 rsecond evisit survey was conducted at Hialeah ALF Inc. on . Deficiencies were found corrected at the time of the survey.	{A 000}		
{A 182} SS=F	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, and interview, the facility failed to ensure three out of eight sampled staff (Staff B, Staff D. and Staff F) were trained in their duties and were responsible for implementing the emergency management plan by being able to unlock the front main gate. Findings included: An observation on at 9:12 AM revealed the facility's front gate bolted shut. At 9:30 AM it was observed as staff unlocked the gate to let residents out for program. Each staff were able to open the entrance gate and gate in the . The residents who reside at the facility did not have a way to exit without the staff letting them out with a key. On at 10:30 AM observed as staff opened the gate for the home health nurse. The	{A 182}		

AHCA Form 3020-0001

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

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{A 182}	Continued From page 1 facility still had a bolt lock on both doors. Class III	{A 182}		