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
	AL11911570	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR DREAM ALF	1630-1640 PALM AVENUE 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
ZZ809	59A-35.062(3)(e)&(7);408.803(7) &.810(8) Proof of Financial Ability to Operate 59A-35.062 Proof of Financial Ability to Operate. (3) Definitions. The following definitions apply to this section for proof of financial ability to operate. (e) "Financial instability" means the provider cannot meet its financial . Evidence such as the issuance of bad checks, an accumulation of delinquent bills, or inability to meet current payroll needs shall constitute prima facie evidence that the ownership of the provider lacks the financial ability to operate. Evidence shall also include the Medicare or Medicaid program's indications or determination of financial instability or fraudulent handling of government funds by the provider. 408.803 Definitions.-As used in this part, the term: (7) "Controlling interest" means: (a) The applicant or licensee; (b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or (c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member. 408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.	ZZ809		

AHCA Form 3020-0001

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

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ZZ809	Continued From page 1 (8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes, and applicable rules. The agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show , provider revenues and expenditures, the basis for financing the , cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider. An applicant applying for change of ownership licensure is exempt from furnishing proof of financial ability to operate if the provider has been licensed for at least 5 years, and: (a) The ownership change is a result of a corporate reorganization under which the controlling interest is unchanged and the applicant submits organizational charts that represent the current and proposed structure of the reorganized corporation; or (b) The ownership change is due solely to the of a person holding a controlling interest, and the surviving controlling interests continue to hold at least 51 percent of ownership after the change of ownership. 59A-35.062 Proof of Financial Ability to Operate.	ZZ809		

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ZZ809	Continued From page 2 (7) An applicant for renewal of a license shall not be required to provide proof of financial ability to operate, unless the licensee or applicant has demonstrated financial instability. If an applicant or licensee has shown signs of financial instability, as provided in Section 408.810(9), F.S., at any time, the Agency may require the applicant or licensee to provide proof of financial ability to operate by submission of: (a) AHCA Form 3100-0009, , Proof of Financial Ability Form, that includes a balance sheet and income and expense statement for the next 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses; and, (b) Documentation of correction of the financial instability, including but not limited to, evidence of the payment of any bad checks, delinquent bills or liens. If complete payment cannot be made, evidence must be submitted of partial payment along with a plan for payment of any liens or delinquent bills. If the lien is with a government agency or repayment is ordered by a federal or state court, an accepted plan of repayment must be provided. This Statute or Rule is not met as evidenced by: Based on observation, interview, and records review, the facility failed to demonstrate financial stability and had an accumulation of delinquent bills and overdrafts. Findings included: Observations on at 6:32 AM showed a live brown insect in one of the empty rooms. Observation on at 7:13 AM showed a broken closet in Resident 's room.	ZZ809		

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ZZ809	Continued From page 3 During an interview on at 7:13 AM Resident # 27 stated that the closet was like that for a long time. Observation on at 7:25 AM showed that the phone in the public area was not functional. During an interview on 07/ at 7:26 AM the Administrator stated that it did not work. Observation on at 7:33 AM The generator did not start. Observation on at 9:34 AM showed a live brown insect in the administrator's office. During an interview on at 9:35 AM the Administrator stated that they have been fumigating for 10 years. Observation on at 10:32 AM showed that there was no functional monoxide detector. Observation on at 7:40 AM showed rusty loud fans in the open-air common area where temperature reached above 86 degrees Fahrenheit. In Resident #22, #23, and #24's rooms the temperature reached 83 degrees Fahrenheit. In Resident # 5's room the temperature reached 84 degrees Fahrenheit. During an interview on at 7:40 AM Resident # 22 stated that it was hot and the air conditioning did not properly work. A review of the electrical bills dated showed due date of . The bills were	ZZ809		

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ZZ809	Continued From page 4 divided as followed: Palm Avenue #1 owed $356.93; #2 owed $44.85; #3 owed $50.82; # 4 owed $1,130.26; and Palm Avenue # 1 owed $182.80; # 2 owed $979.86; #3 owed # 4 owed $45.33; # 5 owed $83.19; #6 owed $1,339.43. The total past due electrical service was $4,270,49. A review of the water bill dated showed past due date was in the amount of $589.05. A review of the facility water bills showed a repayment agreement with the local water department dated for the month of $3,813.15. The agreement stated that commencing through an additional $635.53 per month was due to cure the past due amounts. During an interview on at 11:00 AM the Administrator stated that there was a water leak on the side of city and she needed to get them to give a credit . A review of a notice of cancellation dated showed that the liability insurance was canceled on due to unpaid balance of $6,202.62. A review of a notice of premium due dated showed that a new liability insurance policy for period to had a balance of $13,948.00 with a minimum due of $4,063.00. A review of a notice of cancellation dated showed the new liability insurance was canceled on due to non-payment of premiums. The amount due was $1,100.34.	ZZ809		

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ZZ809	Continued From page 5 A review of the facility bank statements dated showed that there were 3 accounts linked to the facility and one of the accounts had an overdraft from to . The overdraft amount was $12,075.52 on . A review of the facility bank statements dated showed that there were 3 accounts linked to the facility and one of the accounts had an overdraft from to . The overdraft amount was $12,075.52 on . As of , the total amount in the facility's bank accounts was $5,111.07. The total amount owed in immediate past due accounts was $12,816.03. Unclassified	ZZ809		

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A 000	Initial Comments A biennial survey was conducted at Our Dream ALF on - . Deficiencies were found at the time of survey. Class 1 deficiencies were found at tags A0025, A0052, A0054, A0056, A0077, A0078, A0093, A0200 A Class 1 deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The Class 1 non-compliance began on . The facility Administrator was notified of the Class 1 non-compliance on . The census at the start of the survey was 33 residents. The facility failed to provide supervision, coordination of care, medication orders, accurate assistance with medication, therapeutic diets, Automated External Defibrillator use, and emergency power supply. The following is a description of the deficiencies found at the time of the visit: Z809, A0025, A0027, A0052, A0054, A0056, A0077, A0078, A0079, A0093, A0125, A0182, A0190, A0200, AL241.	A 000		

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A 025	Continued From page 1	A 025		
A 025 SS=K	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. (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.	A 025		

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A 025	Continued From page 2 (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 reviews, and interviews, the facility failed to provide appropriate supervision and maintain awareness of the health and well being of three out of 34 sampled residents {Residents #10, #14, #34}. Resident #10 had not received medication for approximately two months. Residents #14 and #34 did not take their medication and the facility did not notify the resident physician. Furthermore, the facility also failed to maintain a written record, updated as needed, of significant changes or illnesses that required medical attention for four out of 34 sampled residents. (#5, #10, # 14, # 34). Findings included: 1) A record review of Resident #10's health assessment dated showed diagnoses of , , II,	A 025		

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A 025	Continued From page 3 , disturbance, and . The health assessment indicated an to peanuts. The Resident required supervision for ambulation/bathing/ . Assistance with self-care and the self-administration of medications and independent with toileting and transferring, the resident had special diet instruction: Diet, Low . A review of Resident #10's progress notes showed that on was transported to a local hospital after she and sustained and and a closed injury. A review of Resident #10's progress notes showed that on was transported to a local hospital because her , was low. A review of the hospital discharge medication order dated and found in Resident #10's file showed that was ordered for Resident # 10's . During an interview on at 9:55 AM the Adminstrator stated that she was not aware that the resident was supposed to be on . Observation on at 10:00 AM showed that there was no at the facility for Resident #10. Further review of Resident #10's progress notes showed that on she sustained another and was found on the floor in her room in a pool of . Additionally, she was taken to the hospital on , diagnosed with hypernatremia (high levels) and high .	A 025		

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A 025	Continued From page 4 According to the Mayo Clinic, not taking could lead to , , , (high sugar levels) that would increase fatigue and/or , , , balance and . These symptoms would also increase the risk of and injury. According to the Mayo Clinic, patient with hypernatremia could have , loss of energy, irritability, , , and/or . These symptoms would also increase the risk of and injury. 2) Observations on at 8:21 A.M. showed plastic and paper containers boxes of unused residents' medications. Resident #14 had several boxes of , Maintena ER 400 mg injectable suspension, with unused doses for , , and . A review of data from Keiser Permanente showed , is an injectable medication used to treat , . A Review of Resident #14's health assessment dated , , with a diagnosis of , . The resident was to fish. The resident needed supervision with bathing/ /self-care, assistance with the self-administration of medications, and was independent with eating/ toileting, and transferring. During an interview on at 8:52 A.M. the Administrator stated that residents had the right to refuse his medication. When asked about the boxes of , Maintena ER 400 mg. The	A 025		

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A 025	Continued From page 5 Administrator also stated that she would just document the refusal in the Medication Observation Record (MOR). When asked for a copy of the MOR for the refusal dates, the Adminstrator stated that she could not find all the refusals. A review of the MOR revealed no indication that Resident #14 refused several months of , , mediation. A Review of the Medication Errors / Omissions Policies and Procedures showed that "any errors or omissions in medications should be reported immediately to the administrator, who will in return report it to the prescribing physician. Action will be taken as advised by physician." Review of Resident #14's progress note showed that there was no documentation of contact with the resident physician when the resident refused medication. Further review showed that on / 2026, Resident #14 was transported to the hospital for , , concerns indicated the Resident #14 was hearing "voices" and , . Furthermore, documentation showed that on , Resident #14 was transported to the hospital for mental health concerns. A facility progress note indicated Resident #14 was sent to the hospital pursuant to the health care provider's orders due to erratic behavior, verbal aggression, paranoia, and , behavior. Moreover, despite the accumulated unused medications, the progress notes stated that the resident was taking the medications. Observation on at 6:25 AM showed that Resident # 34 refused the red liquid filled pill. Resident #2 identified the pill as . A	A 025		

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A 025	Continued From page 6 review of the pre-signed MOR showed that the resident was prescribed 100 Milligrams. Further observation revealed Staff C did not update the refusal in the MOR. A review of Resident # 34's health assessment dated showed diagnoses of , and , . The residents needed supervision with bathing, , and grooming, and assistance with self-administration of medication. A review of Staff C's employment records showed that she last received training on assisting residents with the self-administration of medications on and her hire dated was . A review of Resident # 34's MOR showed no documentation of his refusal of medications on . During an interview on at 2:45 PM Staff D stated that she did not know what to do with the refusals other than just document them and did not know who would review the medication refusals but assumed that the Adminstrator did. A review of Resident # 34's progress notes showed no documentation of any contact with the resident's physician because of medication refusals. A review of the 'Responding to Changes in Residents' Health Status' policy revealed "all staff is obligated to become familiar with the residents and to be aware of changes in residents' health status (physical, emotional and). Any observations of such change will be reported.	A 025		

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A 025	Continued From page 7 Documentation in the form of a progress note will be made of physician orders and outcomes and filed in residents' chart." A review of the progress notes policy revealed each resident was to have a progress note done a monthly basis, "unless otherwise instructed by higher authority." The policy further showed, "Residents will be monitored on a daily basis and any change in status will be documented." Class I	A 025		
A 027 SS=I	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation interview and record review the facility failed to make arrangements for health care as needed, affecting three out of 34 sampled residents (Resident #10, #14, #17). The facility failed to contact Resident #10's and # 14's primary care provider (PCP) when the residents	A 027		

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A 027	Continued From page 8 refused medication or needed follow up . , after resulting in hospitalization. Furthermore, the facility did not provide transportation for Resident #17 during hospital evaluations. Findings included: 1}. On at 8:01 A.M., during the interview the Administrator stated she kept the hospitalization list at home and that the facility had not completed any incident reports since , even though Resident #10 had several times and was once found in her own . The Administrator provided her personal hospitalization list in lieu of providing any documentation from resident records. She stated that the resident had and been injured but 'had not broken her '. On at 8:56 A.M., the Administrator stated that Resident #10 had been hospitalized four times. No current documentation was found, only an undated note that the Adminstrator stated she authored sometime in 2025. The Owner attempted to divert the interview and said, 'I don't know where the documents were.' The Administrator also admitted inconsistencies in the resident's documentation and said the records lacked clear, specific information, including identifying all parties involved and noting who was contacted or when the resident was seen by the doctor. She added that "this would not happen anymore." On at 10:20 A.M., the Administrator stated that Resident #10 did not have a current health assessment reflecting the change in her condition. She added, "I will get an updated one	A 027		

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	AL11911570	A. BUILDING: _____ B. WING _____	07/29/2026

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A 027	Continued From page 9 when she is discharged from [medical facility]." A review of Resident #10's progress notes revealed during the night shift from 7:00 p.m. on to 7:00 a.m. showed that on , staff reported that Resident #10 had been agitated throughout the night. She was screaming out the door toward the outside and running up and down the hallway in an agitated manner. On at 5:00 a.m., Resident #10 was found sitting on the floor with a small injury on her that caused a minor amount of . Staff cleaned the area, applied ice, notified the Administrator, and called 911. She was transported to a medical facility. A review of hospital records showed that on at 8:47 a.m., Resident #10 was treated for a , , , and a closed injury. A review of progress notes showed that on at 8:56 AM, Resident #10's doctor called to ask why the resident had a near her . Staff explained that the was from the that happened on . Later that same day, a visiting nurse saw the resident, evaluated her, and reported that there were no changes in her gait. A review of Resident #10's progress notes showed that on was transported to a local hospital because her , was low. A review of the hospital discharge medication order dated and found in Resident #10's file showed that was ordered for Resident # 10's . In addition, a progress note showed that on	A 027		

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A 027	Continued From page 10 , Resident #10 was discharged from the [medical facility], but the note did not explain why she had been there. It also showed that on , Resident #10 had a syncopal episode, and fire rescue transported her to the [medical facility]. Further review showed that Resident #10 returned to the facility. On at 8:21 A.M., an observation of the Administrator's office bathroom revealed a plastic container in the shower area containing unused medications. The container included Resident #14's , , medication, , Maintena ER 400 mg injectable suspension, with unused doses dated ; ; ; and . On at 8:52 A.M., during the interview, the Administrator stated that residents had the right to refuse their medication. Resident #14 had refused the injectable , , medication. When asked where the documentation was showing the resident's refusal, the Administrator stated that she had written 'Refused' on the Medication Observation Record (MOR). She also stated that she had verbally informed the doctor and documented the lack of compliance in the progress notes, adding that she did not list specific medications because "I'm not a nurse." On at 12:05 P.M., during an interview Resident #14's third party health provider stated that she assisted him with housing and that he had refused his medication in , or while the owner and Administrator were present. She said he was currently not taking any medications. When asked about his hospitalizations, she said she did not know about them and explained that he was usually sent to the hospital due to behavioral changes. She	A 027		

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A 027	Continued From page 11 stated she had no information about the hospitalizations. A review of Resident #14's health assessment dated showed a history of , a fish , and that he was alert, oriented, and mostly independent with daily activities. He required supervision for bathing, , self?care, and assistance with medication. A review of his progress notes showed no medication refusals and indicated he was taking his medications as prescribed. The review also showed several hospitalizations, including a discharge from [medical facility] on at 10:00 A.M A review of Resident #14's Medication Observation Record (MOR) dated showed that the prescribed , Maintena ER 400 mg, to be given , every four weeks, was not administered at any time during , . There was no documentation of any follow?up with the medical provider regarding this issue. In addition, the demographic sheet showed that the listed medical provider was incorrect." 2). A review of Resident #17's progress note dated at 2:00 P.M. showed that staff found the resident agitated, yelling, and physically aggressive toward an employee. Staff encouraged him to go to the hospital for a medication adjustment, but he refused and left, stating he was going to his mother's house. Staff notified his mother, who said she and the resident's brother would locate him using a phone tracking app and take him to the hospital. On , Resident #17 was discharged from the hospital, returned to the facility, apologized for his behavior, and agreed to follow the facility's	A 027		

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A 027	Continued From page 12 rules. All parties were notified. A review of Resident #17's Health Assessment dated showed that the Community Living Support Plan and , Agreement dated were expired. Class II	A 027		
A 052 SS=L	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 13 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 14 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 15 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 observations, interviews and record review that facility failed to follow the state's guidelines when assisting 18 out of 34 sampled residents (#1, #4, #6, #8, #9, #12, #13, #14, #17,	A 052		

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A	Continued From page 16 #18, #20, #22, #25, #27, #28, #32, and #33) with self-administration of medications. Medications were pre-poured into small unlabeled cups and staff lost track of who received the cup with medications. Staff did not verify the resident identity before assisting with medications and did not orally advise the resident of the name and dosage of medications. Findings included: 1) Observations on at 5:34 AM showed that in the medication cabinet all the residents' medications had been pre-poured into small unlabeled cups. (photographic evidence obtained). During an interview on /0226 at 5:35 AM showed Staff C stated that she pre-poured the medications earlier that morning and acknowledged that this was the wrong way to give out medications. Staff C did not answer, yet tilted her , when asked if this was how medications were routinely passed. Observations on at 5:45 AM showed Staff C started passing out the unlabeled cups to residents in the following order. Residents #14, #6, #27, #4, #17, #9, #22, #20, #8, #25, #18, #32, #13, #12, #33, and #1. Further observation showed that Staff C did not verify the identity of residents before giving the cups of medications to the residents, and she did not orally advise any of the residents of the medications contained in the small unlabeled cups. During an interview on at 5:50 AM showed Staff C stated that she was familiar with	A 052		

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A 052	Continued From page 17 the residents and their medications, when asked how she knew which medications cup belonged to their respective resident. Observation on at 6:03 AM showed Staff C while distributing the small cups asked Resident # 18 if he had already received his medications. Staff C was and despite her stated Staff C did not review the MOR and proceeded to give Resident #13 the medications that were intended for Resident #18. Resident # 13 quickly took the medications without hesitation or worry. There were 10 other residents waiting for their medications. A review of Resident # 18's MOR showed he was scheduled to have taken; 10 Milligram; 5 Milligram; 25 mcg; 100 Milligram; Megestrol 40 Milligram; 20 Milligram; 5 Milligram; 100 Milligram; Dioflon 500 Milligram ; 50 Milligram; C 500 Milligram; 10 Milligram; 10 Milligram; 500 Milligram; 0.4 Milligram; 0.5 Milligram; 25 Milligram; 20 Milligram; 10 Gram; 100 Milligram; and 1 Milligram. A review of Resident #18's health assessment dated showed a diagnosis of . The residents needed supervision for ambulation, , and transferring and assistance with bathing, grooming, and toileting. The resident also needed assistance with self-administration of medication. A review of Resident # 13's MOR showed he was scheduled to have taken: 25	A 052		

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A 052	Continued From page 18 Milligram; 1 Milligram; 20 Milligram; 145 Milligram; , . 30 Milligram; , 400 Milligram; 10 Milligram; , 20 Milligram; 325 Milligram; , 2 Milligram; 100 Milligram; , 50 Milligram; , 300 Milligram; , . 2 Milligram. A review of Resident #13's health assessment dated showed diagnoses of , , , , and , , , . He needs assistance with , bathing, grooming and assistance with self-administration of medication. A review of Resident #13's records showed no waiver opting out of advisement of the name and dosage of each of their medications. A review of Staff C's employment records showed that she last received training on assisting residents with the self-administration of medications on and her date of hire was . 2) Observation on at 6:00 AM Staff D was assisting Resident # 17 with his medications. Staff D did not orally advise Resident #17 of the name and dosage of the medications. A review of Resident #17's health assessment dated showed a diagnosis of . He needed supervision with bathing, , and grooming and assistance with self-administration of medication. A review of Resident #17's records showed no	A 052		

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A 052	Continued From page 19 waiver opting out of advisement of the name and dosage of each of their medications. Observation on at 6:20 AM Staff D was assisting Resident # 14 with his medications. Staff D did not orally advise Resident #14 of the dosage of the medications. A review of Resident #14's health assessment dated showed a diagnosis of , . He needed supervision with bathing, , and grooming and assistance with self-administration of medication. A review of Resident #14's records showed no waiver opting out of advisement of the name and dosage of each of their medications. A review of Staff D employment records showed that she last received training on assisting residents with the self-administration of medications on and her hire date was . During an interview on at 11:40 AM the Administrator stated that residents did not have a waiver opting out of the advisement of the name and dosage of their medications. According to the National Coordinating Council for Medication Error Reporting and Prevention, at-risk behaviors for medication error include failing to check patient identification and not ensuring the correct medications were being administered correctly by date and dose. Class I	A 052		

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A 054	Continued From page 20	A 054		
A 054 SS=L	59A-36.008(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. (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 ␣ 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 ␣, 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 observations, interviews and record reviews that facility failed to maintain an accurate and up-to-date medication observation record (MOR) for six out of 34 sampled residents (#1,	A 054		

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A	Continued From page 21 #5, #6, #13, #18, #34) The MOR showed that Resident # 5 received medications after his on .. The MOR was not updated when Resident # 34 refused his medications. The MOR was marked as given when medications had not been given and was not marked when medications were supposedly given. Findings included: 1) Observation on at 6:00 AM showed Resident # 5 was at the facility. During an interview on at 3:26 PM Staff D stated that Resident # 5 was found unresponsive after breakfast on or about 8:20 AM. During an interview on at 9:24 AM the Administrator stated that 911 was called on at 8:53 AM. During an interview on at 9:50 AM the Staff B stated, "[Resident # 5] did not die here, he in the hospital." A review of the hospital records dated showed that the resident expired at 9:13 AM in the hospital. A review of Resident # 5's MOR showed that received his 9:00 PM medications post-mortem on . According to the MOR Resident # 5 allegedly received , 5 Milligram; 20 Milligram; 10 Milligram; and Megestrol 40 Milligram ordered at 9:00 PM.	A 054		

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A 054	Continued From page 22 2) Observations on at 5:34 AM showed that the medication had been pre-poured into unlabeled small cups in the cabinet. (photographic evidence obtained). Observations on at 5:45 AM Staff C started passing out the unlabeled cups to residents. Observation on at 6:25 AM Resident # 34 refused the red liquid filled pill (identified as 100 Milligram), Staff C did not update the refusal in the MOR. A review of Resident # 34's health assessment dated showed diagnoses of , and , . The residents needed supervision with bathing, , and grooming, and assistance with self-administration of medication. A review of Staff C's employment records showed that she last received training on assisting residents with the self-administration of medications on and her hire dated was . A review of Resident # 34's MOR showed no documentation of his refusal on . During an interview on at 2:45 PM Staff D stated that she did not know what to do with the refusals other than just document them and did not know who would review the medication refusals but assumed that the Administrator did.	A 054		

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OUR DREAM ALF	1630-1640 PALM AVENUE HIALEAH, FL 33010

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A 054	Continued From page 23 A review of Resident # 34's progress notes showed no documentation of any contact with the resident physician because of medication refusals. 3) During an interview on at 5:33 AM Staff C stated that residents had not yet been given their medications. A review of the MOR showed that the morning medications had been marked as given to all residents on . Observations on at 5:45 AM Staff C started passing out to residents in small unlabeled cups. Further observations showed that Staff C did not verify the identity of residents before giving the cups of medication to each resident. Observations on at 2:30 PM Staff D was assisting residents with their afternoon medications. Further observation showed that Staff D went to look for a pen. During an interview on at 2:50 PM Staff D stated that she had not marked all the medications yet, and she was aware that she did not mark some. A review of Resident # 13's MOR showed that , 50 Milligram was not marked as given on . A review of Resident #13's medication card showed that , 50 Milligram for was no longer on the medication card.	A 054		

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A 054	Continued From page 24 A review of Resident #13's health assessment dated showed diagnoses of , , , and , , . He needs assistance with , bathing, grooming and assistance with self-administration of medication. A review of Resident # 18's MOR showed that Carbindopa- , 10-100 Milligram was not marked as given on . A review of Resident #18's medication card showed that Carbindopa- , 10-100 Milligram for was no longer on the medication card. A review of Resident #18's health assessment dated showed a diagnosis of , . The residents needed supervision for ambulation, , and transferring and assistance with bathing, grooming, and toileting. The resident also needed assistance with self-administration of medication. A review of Resident # 6's MOR showed that , 3 Milligram and , 200 Milligram were not marked as given on . A review of Resident #6's medication card showed that , 3 Milligram and , 200 Milligram for was no longer on the medication card. A review of Resident #6's health assessment dated showed a diagnosis of , . The residents needed supervision for bathing, , and grooming and assistance with self-administration of medication.	A 054		

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A 054	Continued From page 25 A review of Resident # 1's MOR showed that , 2 Milligram, , 50 Milligram, and , 500 Milligram were not marked as given on . A review of Resident #1's medication card showed that , 2 Milligram, , 50 Milligram, and , 500 Milligram for was no longer on the medication card. A review of Resident #1's health assessment dated showed a diagnosis of , , , and . The residents needed assistance with self-administration of medication. Observation on at 3:30 PM showed that Staff D was updating the missing marks on the MOR. A review of Staff D employment records showed that she last received training on assisting residents with the self-administration of medications on . According to the National Coordinating Council for Medication Error Reporting and Prevention, at-risk behaviors for medication errors include failing to document administration of the medication correctly. Class I	A 054		
A 056 SS=L	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS.	A 056		

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A 056	Continued From page 26 (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 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	A 056		

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A 056	Continued From page 27 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, 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	A 056		

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A 056	Continued From page 28 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 observations, interviews and record reviews, that facility failed to ensure that 11 out of 34 sampled residents (#1, #4, #6, #8, #9, #10, #14, #17, #20, #22, and #25) had medication orders and received their medications in a timely manner. Resident #10 was hospitalized and had a revised medication order that included medications for that were never given. Resident # 1 had a handwritten Medication Observation Record (MOR) which had no accompanying medication orders from a physician. Residents #4, #6, #8, #9, #14, #17, #20, #22, and #25 were given morning medications more than one hour prior to the prescribed time. Findings included: 1) A review of Resident # 10's health assessment dated showed that she was diagnosed with , , Metellus I, , disturbance, and . Resident # 10 required assistance with the self-administration of medciations. A review of Resident # 10 progress notes showed that on was transported to a local hospital after she had a where she sustained and and a closed injury. A review of the hospital discharge medication	A 056		

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A 056	Continued From page 29 order dated showed that was ordered for Resident # 10's . A review the Resident # 10's medication observation order (MOR) showed that was not on list of medications. Observations on at 9:55 AM showed there was no at the facility for Resident #10. During an interview on at 9:55 AM the Adminstrator stated that she was not aware that the resident was supposed to be on . Further review of Resident # 10 progress notes showed that on she sustained another and was found in a pool of . Additionally, she was taken to the hospital on because to hypernatremia and high after losing her. A review of Resident # 10's hospital records dated showed that her level was 344 mg. Further review revealed a diagnosis of . A review of data from the Mayo Clinic revealed, " not taking could lead to (high sugar levels) that would increase fatigue and/or , , balance and . These symptoms would also increase the risk of and injury." 2) A review of Resident #1's MOR showed that the document was handwritten. (photographic evidence obtained).	A 056		

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A 056	Continued From page 30 During an interview on at 10:00 AM the Adminstrator stated that she had a lot to do and hadn't gotten around to it when asked where the orders for the handwritten MORs was. During an interview on at 1:30 PM The pharmacist stated that the prefilled MORs with orders were delivered to the facility with the prescribed medications. The pharmacist stated there were spaces where the facility would need to indicate the medications were administered. A review of Resident #1's health assessment dated showed a diagnosis of , and . The residents needed assistance with self-administration of medication. 3) During an interview on at 5:33 AM Staff C stated that residents had not yet been given their medications. A review of the MOR showed that the morning medications had been marked as given to all residents on . The MOR stated that the medications were ordered for 7:00 AM. Observations on at 5:45 AM Staff C started passing out medications to residents in small unlabeled cups. Residents #14, #6, #27, #4, #17, #9, #22, #20, #8, and #25 received their medications before 6:00 AM. Class I	A 056		

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A 077	Continued From page 31	A 077		
A 077 SS=L	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and 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 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the 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. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (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 chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C.,	A 077		

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A 077	Continued From page 32 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 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, 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 subparagraph (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 59A-36.011, 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.	A 077		

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A 077	Continued From page 33 (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 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 as 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-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review, and	A 077		

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A 077	Continued From page 34 interview, the facility failed to ensure that it was under the supervision of an administrator who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. Ten residents who required specialized diets and/or had food did not receive needed items (Residents #1, #6, #8, #9, #10, #14, #15, #18, #24, and #33). Medications for 19 residents covering the period from through , which had been signed off as given, were stored in a shower in the administrator's office which was accessible to residents. An absence of medication orders resulted in handwritten Medication Observation Records (MOR) which contained medication order errors for two out of 34 sampled residents (Residents #1, #10). Pre-poured medications were observed being given to the wrong resident. Inadequate numbers of poorly trained staff were assigned to care for the census of 29 residents. The facility was financially unstable, with inadequate funds to ensure smooth functioning. The staff were unaware of the emergency procedures, and the facility had no working generator to maintain room temperature at or below 81 degrees Fahrenheit, and no monoxide detector. Resident #2 did not receive medications prescribed for mental health issues. The Administrator failed to ensure that employees were effectively trained regarding , , ( ) and automated external defibrillators ( ). The Administrator also failed to conduct a thorough investigation after Resident #5 was found unresponsive in bed by staff (Cross reference citations #Z809, A0025, A0027, A0052, A0054, A0078, A0079, A0093, A0125, A0182, A0190, A200, AL241).	A 077		

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A 077	Continued From page 35 Findings include: 1) A review of residents and facility records found that ten residents who required specialized diets and/or had food ␣ did not receive needed items (Residents #1, #6, #8, #9, #10, #14, #15, #18, #24, and #33). During an interview on at 8:48 AM, the Administrator stated, regarding the cook denying knowledge of residents with food ␣ and diets, "[Staff E] has been here for so long she knows." 2) Observation on at 8:21 AM revealed unlocked medications filled in Administrator's office bathroom tub. During an interview on at 8:15 AM the Administrator stated, "Yeah residents can come in here at any time they just ask the staff, and staff will leave when they have to use to the phone." Observation on at 9:54 AM revealed a bin of unused medications stored in the administrator's office showed that Resident #34 had several left-over medications for the month of . Medications included , 2 mg (for), , 250 mg (for ,), , 2 mg (for stiffness), , 300 mg (for ,), , 20 Mg (for severe behavioral), , 40 mg (reduces	A 077		

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A 077	Continued From page 36), 1 mg (for health), 100 mg (for), Simvastin 20 mg (lower), and 100 mg (for). Further observation revealed a four-month supply of Resident #2's unused Maintena 400 mg injectable medications. Observation revealed Resident #2 had unopened boxes of Maintena 400 mg injectable for , , and . Record review revealed Resident #2 experienced multiple hospitalizations related to being irate and displaying verbal aggression and from , and . During an interview at 9:28 AM the Owner stated the medications were there because they were scheduled for disposal and belonged to the months of thorough . A review of the facility's disposal of medications policy revealed "all medications that is expired or from the previous month will be discarded/destroyed appropriately." During an interview on at 2:45 PM Staff D (Caregiver) stated that she did not know what to do with the refusals other than just document them and did not know who would review the medication refusals but assumed that the Administrator did. 3) A review of Medication Observation Records found that Residents #1, #4, #6, #8, #9, #10, #14, #17, #20, #22, and #25) had handwritten MOR. Further review found no documentation of accompanying medication orders for the	A 077		

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	AL11911570	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR DREAM ALF	1630-1640 PALM AVENUE HIALEAH, FL 33010

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A 077	Continued From page 37 medications being provided or not provided to residents. A review of resident and hospital records revealed Resident #10 ha been hospitalized and had received a revised medication order that included medications for that were never given. Observation on Residents #4, #6, #8, #9, #14, #17, #20, #22, and #25 were given morning medications more than one hour prior to the prescribed time. 4) Observation on at 5:46 AM revealed that the medications for all residents were pre-poured in the medication's cabinet. Staff C (caregiver) started to give the resident the pre-poured cups of medications. During an interview on at 5:50 AM showed Staff C stated that she was familiar with the residents and their medications, when asked how she knew which medications cup belonged to their respective resident. Observation on at 6:03 AM showed Staff C while distributing the small cups asked Resident # 18 if he had already received his medications. Staff C was and despite her stated Staff C did not review the MOR and proceeded to give Resident #13 the medications that were intended for Resident #18. Resident # 13 quickly took the medications without hesitation or worry. There were 10 other residents waiting for their medications. 5)	A 077		

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A 077	Continued From page 38 Observation on at 6:00 AM revealed Staff C and Staff F opened the door. During an interview on at 6:07 AM Staff C stated the census was 29 residents. During an interview on at 2:59 PM, the Administrator stated, "all the staff continue to be the same, they're the same during the daytime three in the evening and two at night." When asked if more staff were hired. 6) A review of the facility bank statements dated showed that there were 3 accounts linked to the facility and one of the accounts had an overdraft from to . The overdraft amount was $12,075.52 on . As of , the total amount in the facility's bank accounts was $5,111.07. The total amount owed in immediate past due accounts was $12,816.03. 7) During an interview regarding emergency fuel on at 10:56 AM the Administrator stated, "I cannot give you an exact number because we have propane, the city doesn't allow us to have gas on site because when we had it, it was stolen because the company we are with come 24 hours before emergency." When asked how much gasoline was on site. The Administrator added, "that information I don't know I need to check online." When asked how much propane the generator needed for 24 hours.	A 077		

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A 077	Continued From page 39 During an interview on at 7:33 AM Staff C stated she didn't know how to start the generator and didn't know where the evacuation locations were. A review of the in-service and continuing education requirements policy revealed "the facility will provide in-service trainings for staff on the following topics of emergency and evacuation procedures." During an interview on at 10:58 AM when the Administrator attempted to start the generator. The Administrator stated, "gosh these things are hard I know that's how you do it but I'm trying to do it, give me a second I'm trying you kind of heard it start." Observation on at 11:02 AM revealed the emergency power generator didn't start. Observation on at 7:58 AM revealed Staff C didn't know how to test the monoxide detector. During an interview on at 10:27 AM regarding the monoxide detector, the Administrator stated, "I'm going to be honest with you I don't think I have that." 8) Observation on at 8:04 AM revealed Staff D didn't know where the location was. Interviewed on at 2:45 pm, the Administrator stated that Resident #5 became unresponsive at the facility and was transferred to a hospital where he was pronounced .	A 077		

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A 077	Continued From page 40 During an interview on at 3:07 PM Staff E (Cook) stated "we didn't need the (automated external defibrillator) because the rescue came. "When rescue arrived, they were doing (, ,). "When we were on the phone with rescue ... they instructed me to take off his shirt, but we didn't do it because rescue didn't tell us to use and rescue arrived." 10) During an interview on at 3:00 PM when asked if an incident report was filed for Resident #5's . The Administrator stated, "well I was under the impression that I didn't have to put an incident report if they didn't die here." During an interview on at 9:26 AM the Administrator stated, regarding which staff called 911 when Resident #5 was found unresponsive, "I don't have the report in front of me ... most probably (Staff D) or (Staff E) but I need to make sure before I give you that answer." During an interview on at 9:30 AM the Administrator stated, "it was [Staff E] that called 911, I didn't conduct an investigate because (Resident #5) , , at the hospital. The Administrator added, "I believe my employee told you what happened." When asked was there an investigation of Resident #5's . During an interview on at 9:35 AM the Administrator stated, "it was 8:53 AM around that time." When asked what time Staff E called 911. "She used the facility phone number, and 911 will show the facility phone." Observation on at 3:32 PM revealed	A 077		

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A 077	Continued From page 41 on the facility and kitchen phone log an outgoing call at 8:47 AM to the Administrator and at 9:36 AM an outgoing call to (hospital). Further observation of the call log revealed there were no calls made to 911. Class I	A 077		
A 078 SS=L	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 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	A 078		

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A 078	Continued From page 42 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 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, interviews and record review, the facility failed to ensure that all staff were trained in , , ( ) and First Aid. Two out of seven sampled	A 078		

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A 078	Continued From page 43 staff. (Staff D and E, caregivers) did not know how to provide ( ) when Resident # 5 was found unresponsive and were unable to operate the automated external defibrillator ( ). Resident #5 due to a . The facility failed to develop a written job description for three out of seven sample staff. Administrator), Staff C and E (caregivers). Finding included: Observation on at approximate 3:00 P. M revealed on the Administrator's elopement risk list Resident #5's name was not listed. During an interview on approximately at 3:00 P.M., the Administrator stated Resident #5 had , , at the hospital. When asked why Resident #5 was not on the elopement risk list. During an interview on at 3:07 P.M., Staff E (Cook) stated "yesterday, around 8:40 A.M., I went to give [Resident #5] a bath.". Staff E voiced she had given Resident #5 a glass of water and Resident #5 went to the bathroom, then returned to his bed. Staff E stated, "I noticed [Resident #5's] color was pale, I checked for a , , it looked like [Resident #5] was not breathing, so I told [Staff D] to call 911." A review of the facility phone call log revealed on at 8:47 A.M., a call was made to the Administrator and at 9:36 A.M., a call was made to a local hospital. However, there were no calls made to 911. Interview on approximately at 3:10 PM, Staff E stated, "I put [Resident #5's] , placed my near his to check for	A 078		

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A 078	Continued From page 44 breathing, I tried to determine if he was breathing lightly, but he was not breathing." Staff E stated, "I called [Staff D] using my personal phone." However, when asked at what time Staff D was called. Staff E looked at her personal phone call log then voiced instead "I sent a resident to get help; I yelled at a resident who passed by and then started ." Staff E stated, "I started to do the , 30 , he was on the bed.". Staff E stated, "I wasn't going to put my on [Resident #5] I told [Staff D] to find the mouthpiece." Staff E verbalized "[Staff D] grabbed the , when I was giving the blow because we don't give to ." Observation on at 3:31 P.M. revealed the automated external defibrillator ( ) pads were not removed or used. Interview on approximately at 3:10 PM, Staff E also stated, "we didn't need the because the rescue came, when rescue arrived, they were doing , when we were on the phone with rescue they asked us to take off [Resident #5's] shirt but we didn't do it because rescue didn't tell us to use the ." A review of Staff D's employee file revealed Staff D had First Aid training date . Further review, Staff D did not have training in the file. A Review of Staff E's employee file revealed Staff E had and First Aid training dated . A review of the American Red Cross guidelines revealed "If the person does not respond and is not breathing or only gasping, CALL -1 and get equipment, or tell someone to do so. Kneel beside the person. Place the person on their	A 078		

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A 078	Continued From page 45 on a firm, flat surface" Demonstration of the equipment on At 8:04 A.M. Staff D (caregiver) didn't know of the location of the inside the administrator office, it took few minutes to located. Staff D pulled out machine; she did not know how to turn it off and couldn't find where the pads were. A review of Resident #5 Hospital Record showed that he was admitted on at 9:16 A.M., Fire Rescue (FR) arrived on scene at approximately 8:45 A.M. and found Resident #5 , warm to touch, was initialed immediately. FR performs 25 minutes of resuscitative efforts, including 3 doses of and 1 time dose of in route. Residents #5 arrived at Emergency Department (ED) at 9:03 A.M. where code blue was activated, at 9:07 A.M. Resident #5 was intubated at 9:13 A.M. Resident #5 expired. A review Resident # 5's file showed that was admitted on , health assessment (form 1823) dated showed a medical history: ; status: Alert; Resident #5 required supervision with bathing/ /self-care(grooming) and independent with ambulation/ eating/ toileting and transferring, with a regular diet and need assistance with self-administration of medications. Further review the Community Living Support Plan and a , Agreement dated / 2026. During a phone interview on at 9:26 A.M. when asked Administrator, who called 911 when Resident #5 was found unresponsive, stated "hey can I call you right with that	A 078		

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A 078	Continued From page 46 message. I don't have the report in front of me ... most probably [Staff E or Staff D] but I need to make sure before I give you that answer." During a phone interview on at 9:50 A.M. the Administrator stated that [Resident # 5] did not die here, he in the hospital. During a phone interview on at 10:24 A.M., Resident #5's primary doctor had been admitted to him recently. He stated regarding Resident #5, "The first time I saw [him was at the hospital at the beginning of . Furthermore, Primary Doctor stated, " He was referred to because he was declining. I referred him to a and he was doing better. His medications were changed to and according to the recommendations." The Primary Doctor reported that Resident #5 went to the hospital on Sunday for and that the facility called him when the resident was sent home." He further stated that he would sign Resident #5's certificate due to causes. 2) A review of employee records showed that Administrator, Staff C (caregiver) hired on , and Staff E (cook) hired on , did not have a job description on file. Class I	A 078		
A 079 SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum	A 079		

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A 079	Continued From page 47 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 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	A 079		

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A 079	Continued From page 48 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 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	A 079		

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A 079	Continued From page 49 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 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	A 079		

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A 079	Continued From page 50 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 observation, record review and interviews, the facility failed to ensure sufficient and adequate staffing was available to meet the schedule and unscheduled residents'. The facility only had two employees (Staff C and Staff F) assigned to care for 29 residents overnight. Findings include: Observation on at 6:00 AM revealed Staff C (Caregiver) and Staff F (Caregiver) opened the entrance door. During an interview on at 6:07 AM Staff C stated the census was 29 residents. A review of the staffing schedule dated	A 079		

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	AL11911570	A. BUILDING: _____ B. WING _____	07/29/2026

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A 079	Continued From page 51 revealed from 11 PM-7:00 AM revealed Staff C and Staff F were scheduled assigned to the assisted living which totaled 29 residents. During an interview on at 2:59 PM, when asked if more staff were hired. The Administrator stated, "all the staff continues to be the same, they're the same during the daytime, three in the evening and two at night." However, the third staff member is a cook and not a direct care staff. Class III	A 079		
A 093 SS=K	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	A 093		

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A 093	Continued From page 52 habits, preferences, and physical abilities of the 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.	A 093		

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A 093	Continued From page 53 1. Facilities that offer residents a variety of food 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	A 093		

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A 093	Continued From page 54 also be stored, or the facility must have a plan for 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, interviews, and record reviews, the facility failed to follow the menu established by the licensed dietician. meet residents' nutritional needs, Affecting 10 out of 34 sampled residents (Residents #6, #8, #9, #10, #11, #14, #18, #24,#32, and #33). Also failed to have personnel who could identify residents with prescribed special diets, affecting 2 out of 34 sampled residents (Resident #6 and Resident #10). In addition, the facility failed to provide a menu based on the dietary needs for 10 out of 34 sampled residents (Residents #6, #8, #9, #10, #11, #14, #18, #24, #32, and #33). Findings Included: 1). A review of Resident #10's health assessment dated showed diagnoses of , , II, , disturbance, and . The health assessment showed an to peanuts. The Resident required supervision for ambulation/bathing/ . Assistance with self-care and the self-administration of medications and independent with toileting and transferring, the resident had special diet instruction: Diet, Low .A review of Resident #10's record revealed that the resident had two in the facility, and that during the second of these , she was found alone in a pool of her in her room. Further review revealed that the resident was hospitalized On due to an episode of , during	A 093		

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A 093	Continued From page 55 dinner. A review of data from the American Association showed that most often occurs when is too low and the doesn't pump enough to the . On at 7:45 AM, Staff E (Cook) stated she was the cook and had been working there for about five or six years. She said three residents had to fish: Resident #14, #8, and #18. She also said there were five residents: Resident #9, #15, #33, #24, and #32. She said these residents did not follow a special diet; she simply gave them smaller portions, especially less rice, but they ate almost the same food as the other residents. On at 7:45 A.M., during the interview, Staff E (Cook) stated she did not know that Resident #10 had a peanut and instead believed she was to peaches. Staff E reported that Residents #14, #8, and #18 were to fish. She also stated that Residents #9, #15, #24, #32, and #33 were but did not follow a special diet. She explained that she only served them smaller portions, mainly less rice, and that they ate almost the same food as the other residents. On at 11:06 A.M., interviewed Staff E (cook). When asked whether any residents were on a soft diet, she stated "No, all residents eat regular food." When asked how do you identified residents with food , she said, "I have it in my ," . Further she stated that three residents had to fish: Resident #18 and Resident #14. On at At 11:07 A.M., Staff E stated that Resident #10 had an to peaches.	A 093		

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A 093	Continued From page 56 When asked whether any resident had a peanut ␣␣, she stated, "No." She reinforced that only Resident #10 had a peach ␣␣ and that the facility did not serve peaches. When she was asked if she kept a list in the kitchen with residents' names and ␣␣, she stated that she did not. When asked whether the staff who served breakfast knew which residents had ␣␣, she responded, "I don't know, you need to ask them." Regarding the ␣␣ diet, she stated that residents with ␣␣ received regular food but in smaller portions. Review of the menu for the prior six months showed: ␣␣, Dinner: Fish in tomato Sauce no substitutions. ␣␣, Lunch: Tuna Salad (3 oz) with bread (2 slices) (no substitutions. ␣␣ to 7, 2026 Wednesday dinner: Fried fish (3 oz) no substitutions marked. ␣␣, Fried fish (3 oz); no substitutions marked. On ␣␣ at 8:58 A,M., During the interview the Administrator stated that no ␣␣ order had been provided for Resident # 10 until the facility requested a note from the hospital. A review of the menu for the week of ␣␣ - ␣␣ showed that Wednesday's lunch included a 1 ounce cup of sardines, and dinner included a 3 ounce serving of fried fish. Further review found no substitutions or alternates documented. A review of Resident #10's health assessment dated ␣␣ showed a peanut ␣␣ and a ␣␣ diet.	A 093		

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A 093	Continued From page 57 A review of Resident #8's health assessment dated showed a fish . A review of Resident #14's health assessment dated showed a fish . A review of Resident #18's health assessment dated showed a fish and a mechanical soft diet. A review of Resident #33's health assessment dated showed a diet. A review of Resident #32's health assessment dated showed a diet. A review of Resident #24's health assessment dated showed a diet. A review of Resident #9's health assessment dated showed a diet. A review of Resident #6's health assessment dated showed a diet. A review of Resident #11's health assessment dated showed diagnoses of type, and ( ). He needed assistance with self-administration of medication, eating, bathing, , and grooming. No physical or sensory limitations were noted. A review of the menu for the week of to showed that the menu required following portion sizes, using skim milk, using sugar substitutes, providing sugar?free beverages, and offering fruit juices with no added	A 093		

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A 093	Continued From page 58 sugar and fruit packed in its own juice. 2). On at 6:04 A.M., Staff C (caregiver) was observed serving breakfast to the residents. The meal served consisted of a bowl of Corn Flakes with milk, one slice of toast, and juice. No substitution was documented on the menu. A review of the menu for that day reflected for breakfast: Orange Juice (4 oz), Oatmeal (cup), Bread (2 slices) or English Muffin (1), Cream Cheese (1 T), Jelly (1 t), Milk (8 oz), and Coffee or Tea (8 oz). 3). On at 2:55 P.M., during the interview, the Administrator stated that she had already spoken with Staff E about residents' dietary needs. She explained that mechanical soft diets had not changed and that she was working on developing procedures for residents requiring special diets. She added that she would create a list of and residents. However, nothing had been implemented yet. A record review revealed that the Administrator held a Food Safety Manager certificate valid through 05/ 2030. The review also showed that Staff E received Nutritional & Safe Food Handling training on / 2026, as well as Nutrition & Food Service (A?0085) Food Service Designee training on the same date. A review if the American Dietetic Association database revealed Doctors or other clinicians often prescribe a modified texture diet for individuals who have difficulty swallowing (" ") or problems preparing their food for swallowing. Dietary modifications are critical to ensure that individuals with eating difficulties get	A 093		

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A 093	Continued From page 59 adequate nutrition, calories and fluids and to prevent foods or liquids from leaking into airways leading to choking, , , , and , . Class I.	A 093		
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, interview and record review, the facility failed to ensure that six out of seven sampled staff (Administrator, Owner, Staff C, Staff D, Staff E and F) were able to implement the emergency management plan. Findings included: During an interview on at 7:33 A.M., Staff C (caregiver) stated that she did not know how to start the generator. When asked what she would do in an emergency, she replied, "I come here and turn it on." She stated that if there was a fire in a room, I would touch the door to check if it was hot before evacuating, call 911 and wait. Staff C that she did not know the locations of the receiving facilities.	A 182		

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A 182	Continued From page 60 Observation 0 at 7:58 A.M. Staff C were asked to test the monoxide alarm to verify that worked properly. Staff C pushed the button, light turned on but no sounds were heard. Further Staff C stated, I don't know how to test it, says it'll make noise when there's monoxide detected. On at 10:31 A.M., was request to the Administrator operation manual for the monoxide alarm; Administrator stated, "I don't have one." The Administrator made a phone call to a company that installed the alarm, put the phone on speakers, the person stated We do the fire alarm not the monoxide." The Administrator stated, "It's ping pong with them they told me monoxide." The monoxide is not working I have to call another company." Observation on at 10:39 A.M., generator fuel supply on side was six propane tanks, each holding , . Several of the tanks appeared to be low on propane. Owner stated, "If you want, I'm going to call and replace it right now. I have a contract with a company that delivers the supplies before an emergency." When asked if she knew the amount of propane needed for 72 hours or how long the propane supply would last, the owner responded, "You got me. I don't know." During an interview on at 10:45 A.M. asked Staff E (cook) if she knows how to operate the generator, the cook staff stated, "I know how to do it, I press the start button and pull "I know how to do it, but I have , in my arm." During an interview on at 10:47 A. M	A 182		

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A 182	Continued From page 61 Staff D (caregiver) was asked what she will do in case of emergency, she stated the owner had the keys, she did not know the procedures to follow in case of emergency or the location in case of evacuation. During an interview with the Administrator on at 10:56 A.M., regarding how much gasoline was on site, The administrator stated, "I cannot give you an exact number because we have propane." She stated the city did not allow gasoline to keep gasoline on site because it had been stolen in the past. She further stated, "We have a company we are with that comes 24 hours before an emergency." When asked how much gasoline the generator needed to operate for 24 hours, the administrator responded, "That information I don't know; I need to check online." Observation on at 10:58 A.M., Administrator attempted to start the generator. She stated, "Gosh, these things are hard. I know that's how you do it, but I'm trying to do it. Give me a second, I'm trying - you kind of heard it start." When asked what the generator powered, she stated, "This can power the refrigerator, freezer, and the portable air conditioner." Further at 11:02 A.M., Administrator said, "We have an employee who comes and turns it on every two to three months. It's normally a man that does it. The generator did not start. A review of the 2025 Renewal Comprehensive Emergency Management Plan (CEMP) was approved on by the Miami-Dade County Department of Emergency Management. Class II	A 182		

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A 125	Continued From page 62	A 125		
A 125 SS=F	429.27(2) FS; 59A-36.013(3) FAC Fiscal - Surety Bonds 429.27 (2) A facility, or an owner, administrator, employee, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. An owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the consent of the resident. Any facility whose owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility as principal and a licensed surety company. The bond shall be conditioned upon the faithful compliance of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in	A 125		

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A 125	Continued From page 63 advance of such action, giving the reason for the cancellation or nonrenewal. Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection. 59A-36.013 (3) SURETY BONDS. Pursuant to the requirements of section 429.27(2), F.S.: (a) For entities that own more than one facility in the state, one surety bond may be purchased to cover the needs of all residents served by the entities. (b) The following additional bonding requirements apply to facilities serving residents receiving : 1. If serving as representative payee for a resident receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or social security , income plus the payments, including the personal needs allowance. 2. If holding a power of attorney for a resident receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or social security , income; the payments, including the personal allowance; plus the value of any property belonging to a resident held at the facility.	A 125		

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	AL11911570	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR DREAM ALF	1630-1640 PALM AVENUE HIALEAH, FL 33010

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A 125	Continued From page 64 (c) Upon the annual issuance of a new bond or continuation bond, the facility must file a copy of the bond with the Agency Central Office. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed have a minimum surety bond equal to twice the value of the resident's monthly aggregate income, including social security ¸ income (SSDI) and optional state supplement ( ). The facility had a surety bond of $10,000 and was serving as a representative payee for 16 residents and received both SSDI and without adequate bond coverage. Findings included: A review of the surety bond dated showed that the bond amount was $10,000. A review of the bank statements showed that there were 10 residents who received $994 in SSDI and one resident who received $414. (photographic evidence obtained) A review of the income log showed 14 residents received $994 in social security ¸ benefits and one resident received $414. During an interview on at 11:20 AM the Adminstrator stated that she received SSDI benefit for 16 residents. The Adminstrator also stated that she also received $164 dollars in for 16 residents. The Adminstrator stated that she would have to obtain an additional $28,000 in surety bond. Class III	A 125		

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A 190	Continued From page 65	A 190		
A 190 SS=E	59A-36.023( ) & (3)(b) 429.14(6) FS Administrative Enforcement 59A-36.023( ) & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, confirmed long-term care ombudsman program complaints, or confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. For the purpose of this rule, a confirmed long-term care ombudsman program complaint is a complaint that is verified and referred to a	A 190		

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A 190	Continued From page 66 regulatory agency for further action. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 59A-36.006, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 59A-36.013, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 59A-36.007, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 59A36.007, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for , , and transportation to , , ; 5. Section 429.256, F.S., and Rule 59A-36.008, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 59A-36.010, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 59A-36.012, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 59A-36.020, F.A.C., relating to mental health 'residents' community support living plan; 9. Section 429.07, F.S., and Rule 59A-36.021, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and	A 190		

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A 190	Continued From page 67 10. Section 429.07, F.S., and Rule 59A-36.022, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to firesafety, that threaten the life or safety of a resident; 2. Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency.	A 190		

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A 190	Continued From page 68 (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3)(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 59A-36.012, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial onsite consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly onsite corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination.	A 190		

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A 190	Continued From page 69 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to cooperate with agency personnel during the survey and failed to provide requested documents. Findings included: 1). On at 6:10 A.M., observation revealed inconsistent room numbering, resulting in difficulty identifying the location of residents or concerns in the facility. Further observation revealed that the first hallway in the first suite, marked with the number Four, revealed a locked door. On at 6:11 A.M., during an interview, Staff C (caregiver) was asked to open the locked door located in the first room's aisle. She stated, "I do not have the keys." On at 6:43 A.M., Staff C stated that she did not have keys or a master key to unlock the closet inside # , explaining that it was the residents' personal property. She said "we	A 190		

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A 190	Continued From page 70 need to respect the residents." On at 6:46 A.M., in the common area, the emergency exit door was observed locked. Photographic evidence was obtained. On at 6:46 A.M., Staff C stated that the Administrator had the keys needed to open the emergency exit door. Observation revealed that at 6:49 A.M., the Owner arrived. When she was asked about the keys to unlock the exit emergency door, stated, "I have a key all keys are hanging in the office". On at 6:55 A.M., Staff D (caregiver) was observed attempting to unlock the emergency exit door after receiving the keys from the Owner. After trying different keys, she was able to open the door. 2). A review of the medication policies and procedures showed that the facility maintained a form to record the destruction or disposal of discontinued resident medications. On at 8:52 A.M. the Administrator stated that the facility had no written record of the destruction of expired or discontinued medication as defined in the facility policies and procedures. Additionally, she was unable to find , Medication Observation Records (MOR) for any resident. On at 10:20 A.M., the Administrator stated that she did not have a new health assessment for Resident #10 that reflected the change in conditions, and she stated "I will get an updated one when she gets discharged from medical facility [ ]."	A 190		

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A 190	Continued From page 71 3) On at 11:41 A.M.,, the Administrator was asked for Resident #14's nurse information. The information had been requested multiple times the previous day but had not been provided. She stated that the nurse was from [a program] but did not have the nurse's phone number. She called another person to obtain the nurse's contact information and later provided it. Interviewed on at approximately 7:00 am through various times until the completion of the survey, the Administrator was asked to provide documentation of the contract with [ ] hospital which provided her with compensation to care for , homeless persons like Resident #10, who had not received medication for her for over a month, the Administrator never gave the information. Class III	A 190		
A 200 SS=L	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current	A 200		

Agency for Health Care Administration

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A 200	Continued From page 72 licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care	A 200		

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A 200	Continued From page 73 offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain	A 200		

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A 200	Continued From page 74 temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN.	A 200		

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A 200	Continued From page 75 (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation.	A 200		

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A 200	Continued From page 76 (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and	A 200		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR DREAM ALF	1630-1640 PALM AVENUE HIALEAH, FL 33010

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A 200	Continued From page 77 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan.	A 200		

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A 200	Continued From page 78 (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the room temperature was maintained at or below 81 degrees in the common areas. The facility also failed to ensure that it had a functional alternate power source such as a generator to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit in the event of a loss of primary power. The facility failed to ensure that it had a functioning	A 200		

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A 200	Continued From page 79 monoxide detector. The facility failed to maintain for a minimum of 72 hours of fuel onsite to operate the generator in the event of a loss of primary power. Findings include: 1) Observation on at 7:25 AM revealed Resident #5's room temperature was 84.3 degrees Fahrenheit. Observation on at 7:30 AM revealed the temperature in the common area was 86 degrees Fahrenheit. Observation on at 7:40 AM revealed the temperature reading in Resident #22's room was 83.8 degrees Fahrenheit. During an interview on at 7:40 AM Resident #22 stated the temperature in his room was high and that sometimes the air conditioning did not work. Observation on at 10:44 AM revealed the temperature readings in the common area were 86-87 degrees Fahrenheit. Observation on at 5:52 A.M. Resident #6 was at the common area waiting for coffee. She stated "It is hot in here." A review of an room temperature thermometer revealed the temperature was 80.4 degrees Fahrenheit. Observation on at 11:57 AM revealed the temperature reading in the common area increased to 88.5 degrees Fahrenheit.	A 200		

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A 200	Continued From page 80 Observation on at 2:35 PM revealed the temperature reading in the common area was 81.7 degrees Fahrenheit. Observation on at 2:38 PM revealed in the room of Residents #22, #23, and #24 the temperature was 81 degrees Fahrenheit. Further observation revealed an empty room next door temperature was 83.6°F degrees Fahrenheit. A review of data from the National Weather service revealed that the daily high temperatures in Hialeah during the period were: - 93 degrees Fahrenheit. : 92 degrees Fahrenheit. : 92 degrees Fahrenheit. : 92 degrees Fahrenheit. 2) During an interview on at 10:54 AM the Administrator stated, regarding the records for maintenance of the generator, "I don't keep a generator log." Observation on at 10:57 AM revealed the Administrator had to remove a pile of supplies from on top of the generator and pull the generator from the staff storage area to the front of entrance outside to test the generator. The, administrator went to # storage rooms, and started to clean up all the items that were placed on top the generator it took approximately 15 minutes, was sweating, red, she struggled to pull out the generator out of the storage room. Further observation revealed that the generator would not start. During an interview on at 11:02 AM	A 200		

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A 200	Continued From page 81 the Administrator stated, "every two to three months a gentleman comes to test." She further stated, "My husband used to do this." 3) Observation at 7:58 A.M. Staff C was asked to test the monoxide alarm to verify that it worked properly. Staff C pushed the button,the light turned on but no sounds were heard. Further Staff C stated, ' It'll make noise when there's monoxide detected.' During an interview on at 10:27 AM the Administrator stated, "I'm going to be honest with you I don't think I have that," when asked if the facility had a monoxide detector. Interviewed on at 10:31 AM the Administrator stated that the facility did not have a detector. Further observation revealed the Administrator placed a phone call to a company that installed the smoke detector, placed the phone on speaker, and asked the representative to explain where the detector was. The company representative stated that they worked on the fire alarm and they didn't install a monoxide detector. During an interview on at 10:39 AM the Owner stated "if you want, I'm going to call and replace it right now, I have a contract with a company that delivers the supplies before an emergency." When asked if she knew the amount of propane needed for 72 hours the Owner stated, "You got me, I don't know." 4)	A 200		

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A 200	Continued From page 82 Observation on at 10:39 AM revealed 6 propane tanks with labels reflecting that they held , each. Further observation revealed that when lifted, the tanks were light in , appearing to be less that half full. The Owner stated, "If you want, I'm going to call and replace it right now, I have a contract with a company that they deliver it before an emergency." When asked if she knew the amount of propane needed for 72 hours emergency or how long this propane would last, the Owner stated you got me. I don't know." During an interview on at 10:56 AM the Administrator stated, "don't know if we have gasoline on site." "Usually we have gasoline on site, I don't know how many gallons we have here." When asked where the gasoline was stored to use the generator in case of an emergency. During an interview on at 11:02 AM the Administrator stated, "every 3 to 4 months a gentleman comes to test. My husband used to do this," when asked how often the generator was tested. On at 2:55 PM, the Administrator reported the generator was still not working and that she might have a carburetor issue. She stated four or five other generators onsite had similar problems. When asked whether she could complete the needed corrections, she responded, "The facility has been in business for almost 40 years." Class I	A 200		

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AL241	Continued From page 83	AL241		
AL241 SS=E	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the , agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.	AL241		

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AL241	Continued From page 84 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , as follows: a. An affirmative statement on the Alternate Care Certification for , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case	AL241		

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AL241	Continued From page 85 manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , ( ) form, , CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and	AL241		

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AL241	Continued From page 86 will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the of the facility to facilitate and assist the resident in attending and arranging transportation to for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the	AL241		

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AL241	Continued From page 87 immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the	AL241		

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AL241	Continued From page 88 facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation 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 appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that community living support plans were updated for five out of 34 sampled residents (Residents #12,#14, #18, #30, #32). Findings included: On at 10:00 A.M., during an interview, the Administrator stated that she had a lot to do and had not gotten around to the expired community living support plans. A review of Resident #14's records revealed an expired community living support plan dated . The review also showed an expired plan for Resident #32 dated , and an expired plan for Resident #12 dated . A further review revealed expired health assessments for Resident #18 dated / 2025, and for Resident #30 dated / 2025.	AL241		

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AL241	Continued From page 89 Class III	AL241		