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
	AL11965771	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN JUDAS HOME CARE CORP	10720 NW 5 AVENUE MIAMI, FL 33168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ⌄ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure two out of five staff sampled (Staff B and Staff C) were registered with the clearinghouse roster. Findings included: On at 6:20 AM observed Staff B assisted Resident #7 with morning care and at 12:02 PM observed Staff B assisting Resident #4 with eating a pureed meal. On at 10:30 AM Staff B stated she had been working at the facility for 15 days. On at 11:28 AM Staff E stated she had been working in the facility for 15 days. A review of the background screening database and clearinghouse facility roster did not have Staff B and E listed.	ZZ814		

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ZZ814	Continued From page 2 A review of the staff schedule showed Staff E worked on through / 26 from 6 AM to 6 PM. On at 12:10 PM the Administrator confirmed Staff B and Staff E were not listed on roster. Unclassified	ZZ814		
ZZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, with a licensee or provider whose responsibilities require him or her to provide personal care or personal services	ZZ815		

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ZZ815	Continued From page 3 directly to clients, or ◡ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ◡ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.	ZZ815		

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ZZ815	Continued From page 4 (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money	ZZ815		

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ZZ815	Continued From page 5 Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may	ZZ815		

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ZZ815	Continued From page 6	ZZ815		

grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.

(7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining ⎵ , pursuant to s. 943.05(2).

(8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.

435.06 Exclusion from employment.-
(1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity.
(2)(a) An employer may not hire, select, or

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ZZ815	Continued From page 7	ZZ815		

otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07.
(b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits

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ZZ815	Continued From page 8 no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that staff who have access to residents' personal property and living areas had an eligible level II background screening for one out of five sampled staff (Staff E). Findings included: On at 11:30 AM Staff B stated, "When Staff E works, he comes into the facility and takes a bath." On at 12:45 PM the Administrator stated, "Staff E worked to cover when we need	ZZ815		

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ZZ815	Continued From page 9 him." A review of the background screening clearinghouse database found no results of a level II background screening for Staff E hired date unknown. Unclassified	ZZ815		
ZZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ␣ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣ , to the Federal Bureau of Investigation for a national criminal history record check. The ␣ , shall be retained by the Department of Law Enforcement under s.	ZZ816		

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ZZ816	Continued From page 10 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.	ZZ816		

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ZZ816	Continued From page 11 59A-35.090 Background Screening. (d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section	ZZ816		

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ZZ816	Continued From page 12 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have the background attestation file for three out of five sampled staff (Staff B, C, and E). Finding included: Review of Staff B hire date unknown, Staff C hired on , and Staff E's hired dated unknown files revealed they did not have the background attestation of compliance in her record. On at 12:50 PM the Administrator acknowledged Staff B, C, and E did not have the attestation of compliance after reviewing her file. Unclassified	ZZ816		

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A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or . damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a	A 165		

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SAN JUDAS HOME CARE CORP	10720 NW 5 AVENUE MIAMI, FL 33168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 1 preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report	A 165		

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A 165	Continued From page 2 this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that an incident was presented to the risk management and quality assurance program for one out of 18 sampled residents (#6). Findings included: A review of Resident # 6's records revealed a police incident identification card dated . During an interview on at 10:40 AM the Administrator stated that Resident 6's designated power of attorney (POA) threatened her and her family with gun. The Administrator also stated that the POA was always complaining about the treatment of the mother, disputed the terms of the contract, and never signed it. The Administrator further stated that she did not believe that she needed to file the incident with the agency because it did not involve Resident # 6. Class III	A 165		

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A 182	Continued From page 3	A 182		
A 182 SS=H	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that four out of five sampled staff (The Administrator, Staff B, C, and D) were properly trained to implement the emergency management plan. Findings included: Observation on at 6:20 AM showed that Resident # 18 was on . During an interview on at 6:39 AM Staff C stated that she did not know how to manually start the generator and stated that it starts automatically. Observation on at 6:40 AM Staff B and C could not manually start the fixed generator. Observation on at 7:10 AM Staff B and C could not test the monoxide detectors because they did not know where they were.	A 182		

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A 182	Continued From page 4 During an interview on at 7:30 AM Staff E stated that the generator was automatic and could not be manually started. During an interview on at 7:33 AM the Administrator stated that the generator was automatically tested and they cannot manually start it. When asked for the test logs and maintenance records the administration stated "ok." A review of the equipment maintenance log showed that the last documented generator start was . A review of the last equipment maintenance was . Observation on at 8:10 AM the Administrator was on the phone with the generator maintenance company and asked them if they can teach them how to manually test the generator. During an interview on at 11:28 AM Staff B stated that in the event of an evacuation she did not know where resident would need to go but assumed that the hospice resident would need to go to the hospital. During an interview on at 12:30 PM The Administrator stated that she contacted generator maintenance company and was going to teach them how to manually test and start the generator. According to the National Hurricane Center hurricane season begins from and ends on .	A 182		

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A 182	Continued From page 5 Class II	A 182		
A 200 SS=E	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 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	A 200		

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A 200	Continued From page 6	A 200		

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 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

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A 200	Continued From page 7	A 200		

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 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

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A 200	Continued From page 8 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) 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	A 200		

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A 200	Continued From page 9 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. (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	A 200		

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A 200	Continued From page 10 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 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	A 200		

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A 200	Continued From page 11 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. (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	A 200		

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A 200	Continued From page 12 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 observations, interviews, and record review, the facility failed to maintain and test the equipment necessary to implement their emergency environmental control. Findings included: Observation on at 6:40 AM Staff B and C could not manually start the fixed generator. Observation on at 7:10 AM Staff B and C could not test the monoxide detectors because they did not know where they were. During an interview on at 7:25 AM The Administrator stated that the generator was automatic and could not be started. A review of the equipment maintenance log showed that the last documented generator start was . A review of the last equipment maintenance was . Observation on at 8:10 AM the Administrator was on the phone with the generator maintenance company.	A 200		

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A 200	Continued From page 13 Class III	A 200		
AL243 SS=E	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental	AL243		

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AL243	Continued From page 14 health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing	AL243		

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AL243	Continued From page 15 education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on interview and records review, the facility failed to ensure that five out of five sampled staff (Administrator, Staff B, C, D, and E) completed their limited mental health (LMH) training. Findings included: A review of the facility records showed that it was licensed as an LMH facility. A review of employee records showed that none of the employees or administrators had LMH training. Review of Resident #1's health assessment dated [redacted] showed that he was diagnosed with [redacted], and [redacted]. The residents needed supervision with ambulation, and transferring and was needed total assistance with bathing, [redacted], eating, self-care (grooming), toileting, and with the self-administration of medication. During an interview on [redacted] at 12:30 PM The Administrator stated that she would make arrangement for the missing training. Class III	AL243		
A 000	Initial Comments	A 000		

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
	AL11965771	A. BUILDING: _____ B. WING _____	08/27/2026

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A 000	Continued From page 16 A Re-licensure with limited mental health, generator monitoring and complaints investigations (#2026003533 & 2026008854) were conducted at San Judas Home Care Corp. on to . Deficiencies were found at time of the survey.	A 000		
A 010 SS=H	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 17 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 18 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 19 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 20 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and review records, the facility failed to determine the appropriateness of the continued residency for two out of 18 sampled residents (#17 and 18). Resident # 18 was being administered medications by unlicensed staff and could not self-administer her medications. Residents #18 could not transfer to a wheelchair without total physical assistance. Findings included: 1) Observation on at 6:20 AM showed that Resident # 18 was in a hospital bed sleeping, with an concentrator. During an interview on at 6:20 AM Staff B stated that Resident # 18 was under hospice care. A review of the admission and discharge log showed that she was admitted to the facility on . A review of Resident # 18 records showed that she did not have a health assessment, and there was no plan of care. During an interview on at 8:30 AM the Administrator stated that Resident # 18 was switched from hospice care providers. Observation on at 11:00 AM The Hospice Nurse arrived to administer medications for the hospice residents.	A 010		

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A 010	Continued From page 21 During an interview on at 11:09 AM The Hospice Nurse stated that she did not give Resident # 18 medications because there was no order for medication administration. During an interview on at 11:10 AM Staff C stated that she was crushing Resident #18 medications and spoon feeding her the crushed medications with apple puree. She stated that Resident # 18 had a before coming to the facility and could not feed herself or take the medications on her own. Staff C further stated that if she did not give the resident her medications, she would not receive them, and in good conscience not let that happen. During an interview on at 11:36 AM the Administrator stated that the prior hospice for Resident # 18 did not administer medications and that was why they switch the hospice providers. The Administrator stated that they were giving her the medications, until those arrangements were finalized. Observation on at 11:42 AM Staff C was spoon feeding Resident # 18 her crushed medications in a puree apple sauce. During an interview on at 11:14 Resident # 18's son stated that he knew that there was a problem with the hospice nurse not giving his mother his medications but assumed that a nurse was giving her medications. The son further stated that the administrator never informed him that there was a problem with hospice. 2) During an interview on at 6:22 AM	A 010		

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A 010	Continued From page 22 Staff B stated that Resident # 17 was in the hospital because of his , . Staff B stated that he was not in hospice care. Staff B stated that she did not think that Resident # 17 was coming . A review of Resident # 17 records showed that he did not have a health assessment. A review of the Admission and Discharge log showed that Resident # 17 was not on the log. During an interview on at 11:10 AM Staff C stated that Resident # 17 had 's and he could not stand or transfer on his own without them supporting his whole ⌣ . During an interview on at 11:28 AM Staff B stated that Resident # 17 cannot transfer on his own. She stated that they needed to support his ⌣ when he transferred. During an interview on Resident # 17's sister said that he had bad 's and needs a lot of help. Resident # 17's sister also stated that she was at a skill nursing facility before going to this facility. A review of the facility's policy on admission, retention and discharge showed that "...at all time [the resident] must qualify as an eligible resident under ch 429..." the policy also stated that "...the following prevents resident to continue to reside ... more than personal supervision of or assistance with ambulation, grooming, and bathing, eating and ⌣... licensed professional care on 24-hour basis with the exception of administration of medication... and confinement to bed for more than seven consecutive days."	A 010		

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A 010	Continued From page 23 During an interview on at 12:40 AM the Administrator stated that she "will fix it." Class II	A 010		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition	A 031		

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A 031	Continued From page 24 and response to treatment or services ordered by the physician which rnay impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to have care plan by hospice agency for service provided available for one out of six	A 031		

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A 031	Continued From page 25 sampled residents (Resident #18). Findings included: A review of Resident #18's health assessments was found blank. There was no evidence that Resident #18 had an Initial Care Plan provided by hospice agency. On at 12:56 PM the Administrator acknowledged the hospice care plan was not in the resident records. Class III	A 031		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's	A 033		

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A 033	Continued From page 26 record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to have a complete physical care plan for one out of six sample residents (Resident #18). Findings included: On at 6:16 AM Resident #18 was observed in bed with full bedrails upright. On at 11:20 AM Staff C stated, "Resident #18 is and has had a she did not get out of bed." A review of Resident #18's record showed that the resident had a physician's order for full bed rails. A review of Resident #18's 'Care Plan for Physical 's dated showed that it did not indicate the maximum amount of time the resident was to have the applied each day and in what manner and frequency staff would monitor, observe, and report signs of distress to the physician. On at 12:42 PM, the Administrator acknowledged that the care plan did not include the required information. Class III	A 033		

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A 036	Continued From page 27	A 036		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to reduce the risk of the transmission of for one out of six sampled residents (Resident #18). Findings included: On at 11:31 AM Staff C assisted with medications Resident #18 and punched the	A 036		

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A 036	Continued From page 28 medication tablet directly into her gloved . Then crushed the medication tablets into the mortar bowl and the medication tablet directly into small cup. Mix it with applesauce and spoon feed it to the Resident #18. On at 1:46 PM the Administrator confirmed that Staff C should not have touched the medication tablets. A review of employee file revealed that Staff C had the control training on . A review of the policies and procedures for control revealed stated that all employees having direct contact with residents and or material that can directly affect the life or safety of residents will observe universal precautions to minimize or prevent exposures of health care workers and residents to bloodborne A review of the personnel files showed Staff C completed the control training on Class III	A 036		
A 053 SS=G	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication	A 053		

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A 053	Continued From page 29 must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that only licensed staff administered medications to one out of six sampled residents. (Residents #18). Findings included: On at 6:16 AM Staff B stated, Resident #18 is on hospice services."	A 053		

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	AL11965771	A. BUILDING: _____ B. WING _____	08/27/2026

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A 053	Continued From page 30 On at 11:31 AM Staff C assisted with medications for Resident #18 and punched the medication tablet directly into her gloved . Then crushed each of the medication tablets into the mortar bowl and the medication tablet directly into small cup. Mix it with applesauce and spoon feed it to the Resident #18. On at 12:05 PM observed Staff C feeding Resident #18 a pureed lunch, the resident could not hold the spoon. On at 12:30 PM the Administrator stated that Resident #18 was on hospice and needed to have her medications given in her and that hospice was not providing the service of administering medications. That they were working on getting her the services through another hospice company. Interviewed on at 1:00 PM with the Administrator confirmed none of her staff were licensed medical professionals. A review of Resident #18's the medication record showed that the resident was prescribed 500 mg, , 25 mg, , 50 mg, , ER 30 mg, , 25 mg, and , 5 mg. A review of Resident #18's had no health assessment completed and no order for crushed medications. A review of the employee records showed that Staff C had completed six hours of assistance with self-administration of . Further review found no documentation of a medical	A 053		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 053	Continued From page 31 provider's license. A review of the medication records revealed that Resident #18's medications had been signed by staff from ␣ ␣ ␣, to ␣ ␣. A review of the medication record showed the medication was to be given at 7 AM. Class II	A 053		
A 054 SS=D	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.	A 054		

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A 054	Continued From page 32 (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, interview and record review the facility failed to maintain a medication record that showed the directions for use of each medication for one out of six sampled residents (Residents #17). Findings included: On at 11:28 AM a medication reconciliation of Resident #17's medications revealed , - , 25/100 mg tablet was in the medication card. On at 12:47 AM Staff C stated Resident #17 was in the hospital since . A review of the medication record for Residents #17 revealed the medication records showed on had received medication at 7 PM signed by Staff C. A review of the employee records showed that Staff C had completed six hours of assistance with self-administration of Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs	A 056		

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A 056	Continued From page 33 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 resident's medication observation record. The	A 056		

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A 056	Continued From page 34 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 provider must provide the resident with a written	A 056		

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A 056	Continued From page 35 prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure 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 for one out of six sampled residents (Resident #18). Findings included: On at 11:31 AM Staff C (unlicensed staff) was observed crushing Resident #18's medications and administered medication with a spoon. A review of Resident #18's the medication record showed that the resident was prescribed 500 mg, , 25 mg, , 50 mg, , ER 30 mg, , 25 mg, and , 5 mg. A review of Resident #18's had no health assessment completed. And no order for crushed medication is available for review. A review of the medication records revealed that Resident #18's medications had been administered and signed by staff from , , to . Class III	A 056		

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A 077	Continued From page 36	A 077		
A 077 SS=H	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 37	A 077		

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.

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A 077	Continued From page 38 (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, interview, and record	A 077		

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A 077	Continued From page 39 review, the facility failed to ensure that the facility 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. Findings included: (Continued Residency) During an interview on at 11:10 AM Staff C stated that Resident # 18 had a before coming to the facility and could not feed herself or take the medications on her own. Staff C further stated that if she did not give the resident her medications, she would not receive them. Staff C stated that Resident # 17 had 's and he could not stand or transfer on his own without them supporting his whole During an interview on at 11:28 AM Staff B stated that Resident # 17 cannot transfer on his own. She stated that they needed to support his when he transferred. During an interview on at 11:36 AM the Administrator stated that the prior hospice service for Resident#18 did not administer her medications and that was why they switch the hospice providers. The Administrator stated that they were giving her the medications. Observation on at 11:42 AM Staff C was spoon feeding Resident # 18 her crushed medications in a puree apple sauce. During an interview on at 11:14 Resident # 18's son stated that he knew that there was a problem with the hospice nurse not	A 077		

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A 077	Continued From page 40 giving his mother his medications but assumed that a nurse was giving her medications. The son further stated that the administrator never informed him that there was a problem with hospice nurse. A review of the facility's policy on admission, retention and discharge showed that "...at all time [the resident] must qualify as an eligible resident under ch 429..." the policy also stated that "...the following prevents resident to continue to reside ... more than personal supervision of or assistance with ambulation, grooming, and bathing, eating and ... licensed professional care on 24-hour basis with the exception of administration of medication... and confinement to bed for more than seven consecutive days." (Medications) Observation on at 11:42 AM Staff C was spoon feeding Resident # 18 crushed medications in a puree apple sauce. Resident 18 could not self-administer her mediations and was receiving total assistance from staff. A review of the facility's mediation policy showed that assistance with self-administration of medication includes '... placing an oral dosage in the resident had or another container and helping the resident by lifting the container to his or her .' The policy further stated that 'assistance with the self-administration of mediation by an unlicensed person was not considered administration and that administration only occurs by a legally authorized person.' A review of the medication observation records revealed that Resident #18's medications had been signed by Staff C from to	A 077		

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A 077	Continued From page 41 A review of Staff C records showed that she was not a legally authorized person to be administering medications and was only trained in the self-administration of medication. (Uncorrected deficiencies) Observation on at 6:06 AM showed Staff B entered resident rooms without knocking. Observation on at 6:11 AM the staff room was unlocked, and in the staff closet staff kept their medication unlocked. Observation on at 6:21 AM outside by the laundry room there unlocked was bleach stored in a milk bottle labeled "cloro" and floor cleaner. There was powered laundry detergent stored in a vanilla ice cream plastic food container. Observation on at 6:25 showed that there were five cats inside the facility. Observation on at 6:14 AM showed in the kitchen, the refrigerator door observed a bottle of subsalicylate unlocked. Further observation showed a bottle of , and a natural herb tablet on the shelves above were four bottles of food and beverage thickeners unlocked. Observation on at 12:45 PM showed that the facility did not have a working telephone. Observation on at 12:45 PM the facility did not have the hotline number posted in a conspicuous place.	A 077		

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A 077	Continued From page 42 A review of the Admission and Discharge log showed that Resident # 17 was not on the log. Further review of the log showed that Resident #16 was still admitted when he was no longer at the facility. Resident # 2 was discharged to the hospital on and there was no date of . A review Residents # 18 and #17 records showed that did not have a health assessment. Resident # 17 did not have up-to-date progress notes or . Resident # 18 did not have an interdisciplinary plan of care. (Staff) A review of the Administrator's records showed that there was no documentation of the continued Core education training and high school diploma. A review of the facility records showed that it was licensed as a limited mental health (LMH) facility. A review of employee records showed that none of the employees or administrators had LMH training. A review of employee records showed that none of the employees or administrators had LMH training. During an interview on at 7:35 AM The Administrator stated that staff schedule was not correct. The Administrator stated that Staff E was not really an employee but was on call. A review of the background screening clearinghouse database found no results of a level II background screening for Staff E.	A 077		

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A 077	Continued From page 43 A review of Staff E's employee records showed that there were no applications or references for his employment. A review of Staff E's employee records showed that she did not have a valid card documenting completion of First Aid and . During an interview on . at 12:10 PM the Administrator stated that Staff B and Staff E were not listed on roster because she did not have portal access. During an interview on at 12:50 PM the Administrator acknowledged Staff B, C, and E did not have the attestation of compliance after review of her file. A review of Staff B's employee records showed that there were no applications or references for her employment. A review of Staff B's employee records showed that she did not have documentation on pre-service orientation. During an interview on at 11:28 AM Staff B stated that she would call 911 after starting , . Staff B stated that she worked alone the night before. A review of Staff C's records showed that she had no documented First Aid and training. During an interview on at 11:10 AM Staff C stated that if a chocking victim became unresponsive, she would call 911 and get instructions from them. During an interview on at 12:40 PM	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965771	A. BUILDING: _____ B. WING _____	08/27/2026

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A 077	Continued From page 44 The Administrator stated that she would teach the staff again. When asked to describe how to properly render the administrator did not answer. A review of the Administrator records showed that her last statement showing that she was free from communicable was dated . The Administrator hire date was . A review of Staff D records showed that his last statement showing that he was free from communicable was dated . Staff D date of hire was . A review of Staff D's employee records showed that she did not have documentation of training on and . Staff D Hire date was . (Emergency Management) Observation on at 6:40 AM Staff B and C could not manually start the fixed generator. Observation on at 7:10 AM Staff B and C could not test the monoxide detectors because they did not know where they were. A review of the equipment maintenance log showed that the last documented generator start was . A review of the last equipment maintenance was . During an interview on at 12:30 PM The Administrator stated that she "will fix it."	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 077	Continued From page 45 Class II	A 077		
A 078 SS=E	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 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.	A 078		

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A 078	Continued From page 46 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 ˬ 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 observations, interview, and record review the facility failed to ensure that four out of five sampled staff (the Administrator, B, C, and D) were qualified to perform their assigned duties and had evidence that they were free of communicable . Staff B and C did not know how to perform , , ( ). The Administrator and Staff D did not have a statement that they were free	A 078		

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A 078	Continued From page 47 from communicable . Findings included: 1) Observation on at 6:30 AM showed that there were five residents at the facility. During an interview on at 11:10 AM Staff C stated that two residents had do-not- orders ( ). Staff C stated that if a chocking victim became unresponsive, she would call 911 and get instructions from them. During an interview on at 11:28 AM Staff B stated that she believed only two residents had . Staff B stated that she would call 911 after starting , . According to the American Red Cross the protocol for giving was to first check the scene for safety and gather personal protective equipment; check for responsiveness; call 911; place the person on a flat surface; start , 30 at a time centered on the person; followed by two breaths and continue until 911 arrives. The protocol also recommended minimizing interruptions or delays in , . A review of Staff B's records showed that she had First Aid and training on and . A review of Staff C's records showed that she had no documented First Aid and training. During an interview on at 12:40 PM The Administrator stated that she would teach the	A 078		

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A 078	Continued From page 48 staff again. When asked to describe how to properly render the administrator did not answer. Observation on at 12:42 PM the Administrator asked Staff B where her training was. Staff B replied that she did not know. 2) Observation on at 11:00 AM Staff D was at the facility and helped move a resident bed out of the room. A review of the Administrator records showed that her last statement showing that she was free from communicable was dated . The Administrator hire date was . A review of Staff D records showed that his last statement showing that he was free from communicable was dated . Staff D date of hire was . During an interview on at 12:30 PM The Administrator stated that Staff D did not have contact with residents. The Administrator further stated that she "will fix it." Class III	A 078		
A 079 SS=E	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week:	A 079		

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A 079	Continued From page 49	A 079		

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 documenting completion of such courses must be in the facility at all times.

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A 079	Continued From page 50 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 apartments, must have enough qualified staff to provide resident supervision, and to provide or	A 079		

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A 079	Continued From page 51 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 by the agency to determine if it sufficiently increases the staffing levels to meet resident	A 079		

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A 079	Continued From page 52 needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and records review the facility failed to ensure adequate staffing standards. The facility's staff schedule did not reflect a 24-hour staffing pattern. Staff B was alone at the facility with five residents and three of five required life saving measures. 1) Observation on at 6:10 AM showed that Staff B and C were the only two staff at the facility. A review of the staff schedule showed that Staff B was scheduled "off" on and was scheduled to work from "6:00 AM to 6:00 PM" on . Staff C was also scheduled "off" on and was scheduled to work from "6:00 AM to 6:00 PM" on . Staff E was scheduled from "6:00 PM to 6:00 AM" on	A 079		

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A 079	Continued From page 53 and . During an interview on at 7:35 AM The Administrator stated that staff schedule was not correct. The Administrator stated that Staff E was not really an employee but was on call. 2) During an interview on at 11:28 AM Staff B stated that she worked alone the night before. Staff B stated that she would call -1 after starting , . Staff B stated that she had never met Staff E but believed that he slept in the shed. A review of Staff B's records showed that she had First Aid and training on /20205 and . According to the American Red Cross the protocol for giving was to first check the scene for safety and gather personal protective equipment; check for responsiveness; call -1; place the person on a flat surface; start , 30 at a time centered on the person; followed by two breaths and continue until -1 arrives. The protocol also recommended minimizing interruptions or delays in , . Class III	A 079		
A 081 SS=E	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by	A 081		

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A 081	Continued From page 54 the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously	A 081		

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A 081	Continued From page 55 completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including	A 081		

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A 081	Continued From page 56 chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

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A 081	Continued From page 57 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one out of five sampled staff (Staff B) completed their pre-service orientation. Findings included: A review of Staff B's employee records showed that she did not have documentation on pre-service orientation. During an interview on at 11:28 AM Staff B stated that she started working at the facility like 10 or 15 days ago. During an interview on at 12:30 PM The Administrator stated that she "will fix it." Class III	A 081		
A 082 SS=E	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.	A 082		

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
	AL11965771	A. BUILDING: ________ B. WING ________	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN JUDAS HOME CARE CORP	**10720 NW 5 AVENUE** **MIAMI, FL 33168**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 082	Continued From page 58 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one out of five sampled staff (staff D) completed the one- time education course on , ( ) and ( ). Findings included: A review of Staff D's employee records showed that she did not have documentation of training on and . Staff D Hire date was . During an interview on at 12:30 PM The Administrator stated that Staff D did not have contact with residents. The Administrator further stated that she "will fix it." Class III	A 082		
A 083 SS=E	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training	A 083		

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A 083	Continued From page 59 is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one out of five sampled staff (Staff E) have a valid First Aid and , , ( ) card. Findings included: A review of the staff schedule showed that Staff E was scheduled from "6:00 PM to 6:00 AM" on Sundays through Friday for the . No other employee was scheduled from 6:00 PM to 6:00 AM except for Staff D on Saturdays. A review of Staff E's employee records showed that she did not have a valid card documenting completion of First Aid and . During an interview on at 8:51 AM The Administrator stated that Staff E was on call staff, but the schedule was not correct. Class III	A 083		
A 092 SS=E	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the	A 092		

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A 092	Continued From page 60 administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and records review, the facility failed to ensure safe food handling. Findings included: Observation on at 6:30 AM showed	A 092		

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A 092	Continued From page 61 that on the outside of the facility where the laundry machine was located there were root vegetables and bananas being stored outside. Further observation showed that there were several cats outside as well. A review of records showed that the Administrator completed her nutritional and safe food handling training on . Observation on at 12:30 PM showed that there was plumber unclogging sewage pipe near where the bananas and roots were stored. According to the center for control, ingesting germs can lead to food , , and the elderly and frail were at a higher risk of complication from foodborne illnesses. Class III	A 092		
A 161 SS=E	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member	A 161		

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A 161	Continued From page 62 must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ␣ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record	A 161		

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A 161	Continued From page 63 review the facility failed to ensure copies of personnel records for three out of five sampled staff (Administrator, Staff B and E). The Administrator did not have a copy of her core continued education or high school diploma in her personnel record. Staff B and Staff E did not have a copy of the application with references in their personnel file. Findings included: 1) A review of the Administrator's records showed that there was no documentation of the continued core education training and high school diploma. During an interview on at 8:18 AM the administrator stated that the records should be in the file. She stated that she finished the training but does not know where the copy went. Observation on at 8:19 AM the Administrator was looking through her phone for the record. Further, observation showed that the Administrator produced printed copies of the Core education training. 2) Observation on at 6:10 AM Staff B answered the door. During an interview on at 11:28 AM Staff B stated that she started working at the facility like 10 to 15 days ago. A review of Staff B's employee records showed that there were no applications or references for her employment. A review of the staff schedule showed that Staff E	A 161		

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A 161	Continued From page 64 was scheduled from "6:00 PM to 6:00 AM" on Sundays through Friday for the . During an interview on at 8:51 AM The Administrator stated that Staff E was on call staff, but the schedule was not correct. A review of Staff E's employee records showed that there were no applications or references for his employment. During an interview on at 12:30 PM The Administrator stated that she "will fix it." Class III	A 161		