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
	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM F/F INC	34 W 14TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 058 SS=E	429.42( ) FS; 59A-36.023(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 59A-36.023(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 59A-36.008, F.A.C., is documented by agency personnel pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as	A 058		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 058	Continued From page 1 determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of a class I or class II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility is required to employ the consultant services or a licensed registered nurse or pharmacist and a registered dietician to provide onsite quarterly consultations until it is determined that such consultation services are no longer required. The facility had Class II deficiencies regarding medication and dietary services. Findings included:	A 058		

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A 058	Continued From page 2 A) Assistance with self-administration of medication: On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not realize that the resident had left two pills on her breakfast plate. Resident #9 then approached the table and picked up the leftover slice of bread that was on the same plate as the two pills. Staff B, unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." On at 6:49 A.M., Staff B observed assisting Resident #6 with the self-administration of medications. Staff B placed her inside the medication bottle, picked up the pill into a disposable cup, and observed the resident swallowing the medication. B) Medication record: Observation on at 6:18 A.M. Staff B (caregiver) called out Resident #5 name to take one of her medications that dropped early. Resident #5 walked to the dining table, Staff B dropped pills into resident , observed resident swallowing the pills. A review of the Resident #5 medication observation record (MOR's) showed 7:00 A.M. medication Icosepent 1 milligrams (mg) two times a day, -10 mg one time a day 75 mg and 25 mg where not initialed on by staff. C) Medication storage and disposal: On at 5:48 A.M., observed a room door marked as an office that was unlocked. Inside, a metal cabinet containing a large amount	A 058		

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A 058	Continued From page 3 of prescribed medication was also unlocked. On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not realize that the resident had left two pills on her breakfast plate. Staff B (caregiver), unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." On at 7:00 A.M. observed Staff B removed the plate and disposed of the pills in the trash, stating that she would request replacement pills from the pharmacy and give them the next day. During an interview on at approximately 7:05 A.M., Staff C (caregiver) stated that the usual procedure is to store medications for proper disposal and provide them to the administrator. She added that she believed Staff B was nervous, which was why she threw the pills into the trash can. D) Dietary services: On at 7:30 AM, during breakfast, all residents were observed eating a regular diet of two slices of bread, cereal, Ensure, and orange juice. Photographic evidence obtained. On at 7:30 AM, Staff C (Caregiver) stated in an interview that she worked as a cook and also helped residents with self?administration of medications. On at 9:40 AM, when asked whether any residents had special diets, Staff C said there were none. She explained that if a resident did	A 058		

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A 058	Continued From page 4 not like the food, she would make a sandwich instead. When asked about an alternative menu, she said she did not know. A review of records showed that Resident #4's health assessment dated listed a mechanical soft diet with thin fluids. Resident #5's health assessment dated listed a mechanical soft diet, No Concentrated Sweets (NCS), and a diet. Resident #6's health assessment dated listed a diet. Resident #9's health assessment listed an NCS diet. On at 9:54 AM, during an interview, the Administrator was asked for the required six months of original menus but could not find them. A review of facility records showed that the facility did not have any menus from the past six months. Class III	A 058		
A 075 SS=E	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility.	A 075		

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A 075	Continued From page 5 (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and a review of records, the facility failed to have a working automated external defibrillator ( ) on site and failed to ensure that staff were able to operate it. This affected 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included: On at 9:10 AM, the was observed sitting on top of a cabinet in the dining area, making it difficult for staff to reach quickly in an emergency.	A 075		

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A 075	Continued From page 6 On at 9:10 AM, during an interview, Staff C (Caregiver) stated that she did not know how to use the . explaining that she had never been in a situation where it was needed. A review of the pads showed they had an expiration date of . Class III	A 075		
A 077 SS=E	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	A 077		

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A 077	Continued From page 7 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., 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	A 077		

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A 077	Continued From page 8	A 077		

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.
(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

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A 077	Continued From page 9 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 interviews and a review of records, the facility failed to have a capable administrator to oversee operations, maintain the facility, and ensure appropriate care for all residents. This affected all 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included: On at 9:32 AM, during an interview, the Administrator stated that she did not know how many residents received and said she would need to contact someone else to find out. On at 9:54 AM, the Administrator stated that the facility did not have any residents with special diets and confirmed that they did not have a six month menu with substitutions. On at 10:00 AM, during an interview, the Administrator was asked whether she worked as an administrator in five different locations. She responded, "I do not." A review of the clearinghouse screening management system showed that the Administrator was listed as the administrator in five different facilities and also appeared as an	A 077		

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A 077	Continued From page 10 assistant. Class III	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	A 078		

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A 078	Continued From page 11 education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility , to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and a record review, the facility did not ensure that staff were qualified to perform their assigned duties for 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included:	A 078		

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A 078	Continued From page 12 On at 5:30 AM, Staff D (Caregiver) was observed working alone during the night shift and was responsible for 21 residents. On at 6:30 AM, during an interview, Staff D showed no knowledge of emergency procedures and did not know where residents should go or how they would be evacuated. A review of the Administrator ' s records dated showed that the test results had been overwritten in red and black ink. Class III.	A 078		
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 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	A 083		

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A 083	Continued From page 13 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 interviews and record reviews, the facility failed to ensure that staff were able to how they would perform , , ( ) and First Aid procedures, affecting 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included: On at 6:30 AM, during an interview, Staff D (Caregiver) stated that she had only been in the country for a few months. She did not remember the correct steps for assisting an unresponsive resident. Observation during the interviwed showed Staff D did not know where to put her during , did not know the proper number of , , , did not identify that she would check for a , , and did not say or demonstrate that she would provide breaths. She also stated that if a resident was choking, she would press on the abdomen or hit the resident ' s before calling for help. On at 9:10 AM, during an interview, Staff C explained how she would respond in an emergency. For an unresponsive resident, she said she would start with 60-100 , but did not mention checking for a , first or giving rescue breaths. For a choking resident, she stated she would give blows, place the resident on the floor, and call 911 and the administrator. She added, "I never had this experience before."	A 083		

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	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

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ADAM F/F INC	34 W 14TH STREET HIALEAH, FL 33010

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A 083	Continued From page 14 A review of records showed that Staff D had valid training through , and Staff C had valid training through . Class III.	A 083		
A 093 SS=E	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed	A 093		

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A 093	Continued From page 15 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide	A 093		

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A 093	Continued From page 16 notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to prepare and serve therapeutic diets as ordered by the health care provider. In addition, the facility failed to substitute menu items with comparable nutritional value and did not keep records of the menu substitutions for	A 093		

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A 093	Continued From page 17 the required six months. These issues affected 3 of 20 sampled residents (Residents #4, #5, and #6). Findings included: On at 7:30 AM, during breakfast, all residents were observed eating a regular diet of two slices of bread, cereal, Ensure, and orange juice. Photographic evidence obtained. On at 7:30 AM, Staff C (Caregiver) stated in an interview that she worked as a cook and also helped residents with self administration of medications. On at 9:40 AM, when asked whether any residents had special diets, Staff C said there were none. She stated that if a resident did not like the food, she would make a sandwich instead. When asked about an alternative menu, she said she did not know. A review of records showed that Resident #4's health assessment dated listed a mechanical soft diet with thin fluids. A review of Resident #5's health assessment dated listed a mechanical soft diet, No Concentrated Sweets (NCS), and a diet. Resident #6's health assessment dated listed a diet. Resident #9's health assessment listed an NCS diet. On at 9:54 AM, during an interview, the Administrator was asked for the required six months of original menus but could not find them. A review of facility records showed that the facility did not have any menus from the prior six	A 093		

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A 093	Continued From page 18 months. Class II	A 093		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use.	A 152		

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A 152	Continued From page 19 (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to Provide a safe living environment free of hazards, ensuring that all exiting architectural, and mechanical structure, are safe for 20 out of 20 sampled residents. (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings Included: Observation on at 5:48 AM showed an unlocked bathroom with cleaning products, bleach, bathroom cleaner, shower cleaner, floor , and other cleaning products. Observation on at 6:10 AM showed the ceiling inside the administrative office was severely cracked and broken. Observation on at 6:30 AM The Common area beside the water fountain, the door was broken at the bottom, pealing and torn off. In an exit conference on 11:52 AM, the Owner stated that he was not aware of the concerns. He said the administrator did not inform about the severe cracks at the facility. Class III	A 152		
A 160 SS=E	59A-36.015(1) FAC Records - Facility	A 160		

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A 160	Continued From page 20 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the	A 160		

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A 160	Continued From page 21 county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the	A 160		

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A 160	Continued From page 22 last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to keep residents' records securely locked. The facility also failed to ensure that records were accurate and protected from falsification. Findings included: On at 6:00 AM, during a tour of the patio area, unlocked facility records were observed in two closets. These records were accessible to anyone entering the patio area. Photographic evidence was obtained. On at 5:50 AM., the Administrator's office was observed open with unlocked resident records and medications inside.	A 160		

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A 160	Continued From page 23 On at 7:40 AM, Staff B was observed signing the Medication Observation Record (MOR) before providing medications to Residents #4 and Resident #9. On at 8:00 AM, the Administrator was observed telling Staff B that she needed to erase something from the MOR when it was requested for inspection. On at 6:11 AM, Resident #7's bed was observed with a full bed rail attached. Staff B stated that the resident had full bed rails because she could not transfer independently and the rails were used to prevent her from falling. A review of Resident #7's health assessment showed no evidence of a prescription for full bed rails. A review of Resident #1's health assessment dated revealed , , as a diagnosis, but the resident's diet was listed as regular. A review of facility records showed inaccurate admission and discharge logs, with many fields covered in whiteout and overwritten. Class III.	A 160		
A 200 SS=D	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 200		

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A 200	Continued From page 24 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 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	A 200		

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A 200	Continued From page 25 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 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	A 200		

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A 200	Continued From page 26 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 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.	A 200		

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	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM F/F INC	34 W 14TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 200	Continued From page 27 (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 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	A 200		

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A 200	Continued From page 28 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 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	A 200		

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A 200	Continued From page 29 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 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	A 200		

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A 200	Continued From page 30 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 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 reviews, the facility failed to ensure that all staff	A 200		

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A 200	Continued From page 31 were trained to implement emergency management procedures and failed to ensure that it could keep indoor temperatures at or below 81 degrees during an emergency. Findings included: On at 11:10 AM,. A fixed generator was observed in the patio area. On at 11:15 AM., during an interview, Staff C (Caregiver) was asked to turn on the generator. She had difficulty opening the top, and once it was open, she was unable to turn it on. In addition Staff C stated that she believed the generator was diesel-powered but that she was not sure. She also said the generator powered the entire house and that the facility did not have any cooling devices. On at 11:34 AM., during an interview, the Administrator stated that she did not know how much fuel would be needed to keep the generator running for 72 hours during an emergency. When asked about cooling devices, the Administrator said they did not need any because the generator powered the air-conditioning unit. She also did not know that the maximum allowable indoor temperature was 81 degrees Fahrenheit. The Administrator stated that the facility had a fuel contract with the city but could not provide a copy of the contract. A review of facility records showed no evidence of a city fuel contract for the generator. Class III.	A 200		

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A 000	Continued From page 32	A 000		
A 000	Initial Comments A biennial with generator survey was conducted at Adam F/F Inc, on , , . Deficiencies were identified at the time of survey.	A 000		
A 007 SS=G	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least , , . 2. Be free from signs and symptoms of any communicable that is likely tomay be transmitted to other residents or staff. AnHowever, an individual who has , ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. In addition, an individual that exhibits signs or symptoms of or has been diagnosed with a , , illness that can be spread through droplet transmission, may be admitted, at the administrator's discretion, if appropriate droplet precautions are implemented by facility staff. Appropriate droplet precautions include recommendations from nationally accepted standards, recommendations from the local county health department, and the facility's prevention and control policies and procedures at the time of the individual's admission. The individual must otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one	A 007		

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A 007	Continued From page 33 person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a health care practitioner, or a mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 10. Not have any ␣ or 4 , . A resident requiring care of a ␣ , may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to	A 007		

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A 007	Continued From page 34 provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care practitioner; b. The condition is documented in the resident's record and admission and discharge logs; and, c. 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. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or f. Treatment of surgical or , unless the surgical or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. , and , performed in the facility; b. , , performed in the facility. 13. Not require 24-hour nursing supervision,	A 007		

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A 007	Continued From page 35 unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by Section 429.26, F.S.; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable ,,, or assistance with routine , care of site , placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from , with a licensed third party to provide the assistance if	A 007		

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A 007	Continued From page 36 the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) Not withstanding any other provisions of this rule, an individual enrolled in and receiving licensed hospice services may be admitted to an assisted living facility pursuant to Section 429.26(1)(d), F.S. (e) Resident admission criteria for facilities 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, review, and interviews, the facility failed to ensure that one out of twenty sampled residents met admission criteria. Resident #2, who had a , was admitted without ensuring the facility could provide or arrange the necessary services within the scope of his license. Findings include: On at 5:57 A.M., observed Resident #2 in bed with a , bag hanging from the bed. The bag contained dark, bloody liquid. During an interview on at 5:57 A.M. Staff B (caregiver) stated that she emptied the bag for Resident #2 and she did not receive training to do it. A review of the home health agency's patient care order for Resident #2's showed that services included , care by a home health services (HHS) registered nurse (RN), maintaining the , to gravity drainage,	A 007		

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A 007	Continued From page 37 monitoring output, hematuria, patency, and signs of ( ), and providing /, care and irrigation as needed (PRN) for. However, the order was incomplete and the services were not being provided (Photographic evidence obtained). A review of data from Mayo Clinic showed, "A is a medical device that helps drain from your , healthcare provider uses if you have a condition that makes it difficult to pee. Empty your collection bag every two to three hours. If you have a larger collection bag, empty it every eight hours." A review of the home health agency file showed no documentation of service having been provided to Resident #2, and showed no records of the resident's output. A review of the admission procedures, appropriateness of placement and continued residency criteria policies showed: (f). "Assisted living facility staff may provide any nursing services 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 scoop of their professional licensure or training". During a phone interview on at 3:42 P.M., the home health agency [case manager] stated that Resident #2 's care order had been opened the previous day with them, on . He stated that the agency typically provided one or two visits to teach assisted living facility (ALF) staff how to empty the bag. Class II	A 007		

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A 010 SS=D	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, 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	A 010		

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A 010	Continued From page 39 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 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.	A 010		

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A 010	Continued From page 40 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 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	A 010		

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	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

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A 010	Continued From page 41 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 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, record review and interview, the facility failed to ensure that one out of 20 sampled residents met the continuing residency criteria (Resident # 7).	A 010		

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A 010	Continued From page 42 Findings included: On at 5:54 A.M., I observed Resident #7 in bed with two bed rails attached, creating a full bed rail. On at 5:55 A.M., Staff B (caregiver) stated that Resident #7 was not receiving hospice care and that the bed rails were used to prevent her from falling out of bed. On at 6:38 A.M. two staff were observed assisting Resident #7 with activities of daily living diapers changes. During an interview at around 6:37 A.M. Staff E (caregiver) stated that Resident #7 was rigid and needed the assistance of two persons. On at 11:59 A.M., observed Resident #7 being spoon fed by Staff E. The resident's , were closed, and were placed on the table. During an interview on at 11;59 A.M., Staff E stated that sometimes Resident #7 ate by herself, but most of the time, when she did not want to eat, that she fed the resident. Staff E also stated, "Today it took us a lot to get her out of bed; she is very rigid." A review of Resident #7's record showed was admitted on , health assessment dated with diagnoses of Type - unspecified , , , ( ), high , , , multifocal . The assessment stated the resident was independent with ambulation and eating, need supervision with toileting and	A 010		

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A 010	Continued From page 43 assistances with bathing, ⎵, self - care and transferring, regular diet and need assistance with self-administration of medications. A review of the admission procedures, appropriateness of placement and continued residency criteria policies showed: 4. (d) "the facility administrator is responsible for monitoring the continued appropriateness of placement of a resident at all the time". 5. Discharge "if the resident no longer meets the criteria for continue residency, or the facility is unable to meet the resident's need, as determined by the facility administrator or healthcare practitioner, the resident must be discharge." Class III	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	A 031		

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A 031	Continued From page 44 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 and response to treatment or services ordered by the physician which may 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,	A 031		

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A 031	Continued From page 45 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 observation, record review, and interview, the facility failed to ensure that a third party home health agency received a complete physician ordered treatment plan for 1 out of twenty sampled residents (Resident #2). Findings include: On at 5:57 A.M., observed Resident #2 in bed with a , bag hanging at the bedside containing dark, bloody liquid. A review of the home health agency's patient care order for Resident #2 showed that services included , care by a home health services (HHS) registered nurse (RN), maintaining the , to gravity drainage, monitoring output, hematuria, patency, and signs of , ( ), and providing , /, care and irrigation as needed PRN for. The order was incomplete. (See photo). During a phone interview on at 3:42 P.M., the home health agency [case manager] stated that the discharge order was not complete and the assisted living facility (ALF) or the resident needed to contact the primary care provider (PCP)or , to determine where and	A 031		

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A 031	Continued From page 46 how often the needed to be changed. Class III	A 031		
A 032 SS=E	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo	A 032		

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A 032	Continued From page 47 identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interviews and a review of records, the facility failed to ensure that staff were knowledgeable about its elopement policies and procedures for 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included:	A 032		

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A 032	Continued From page 48 On at 9:15 AM, Staff C (Caregiver) stated during an interview that if a resident eloped, she did not mention notifying the resident ' s family. She only said she would call the administrator, call the police, and check the facility. She also did not mention giving the resident ' s photo to the police. On at 9:18 AM, Staff C stated that she had worked at the facility for almost 12 years and had never taken part in an elopement drill. On at 11:45 AM, the Owner stated during an interview that he did not know why staff could not remember participating in elopement drills. A review of the elopement drill log showed that the most recent drill was completed on . Class III	A 032		
A 034 SS=E	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while	A 034		

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A 034	Continued From page 49 rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that residents ' assistive devices were cleaned, kept in good working condition, and free of hazards. Findings included: On at 6:05 AM, during a tour of # , an unclean bath chair with visible rust was observed. This same issue was noted for Residents #7 and #8. On at 6:05 AM, during an interview, Staff E (caregiver) stated that they cleaned bath chairs only once a day. A review of the facility ' s policies and procedures showed that staff were required to clean the bath chair before each use. Class III	A 034		
A 036 SS=F	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	A 036		

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A 036	Continued From page 50 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, and interviews, the facility failed to implement control procedures for 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings Included: 1) Observation on at 6:45 AM showed Staff B (caregiver) passing medications using gloves, then touching surfaces, such as tables, keys and clothing. Further observation revealed she did not sanitize or wash her or consistently change gloves between activities. 2) Observation on at 6:14 AM showed	A 036		

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A 036	Continued From page 51 the residents' bathrooms each had a shower chair, and commode in the shower used by all residents sharing the bathrooms. In an interview conducted on at 6: 16 AM, Staff E who stated the shower chair is clean once per week with bleach and . Class III	A 036		
A 052 SS=G	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	A 052		

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A 052	Continued From page 52 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

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A 052	Continued From page 53 (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , _ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's	A 052		

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A 052	Continued From page 54 health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that trained staff observed residents taking medication. Resident #1 left pills	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

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A 052	Continued From page 55 on her breakfast plate, creating a direct risk to other residents. In addition, the facility staff failed to adhere to the facility's control when assisting one out of twenty sampled residents with self-administration of medication (Resident #6). Findings include: On at 6:21 A.M., observed Staff B (caregiver) punching pills into disposable cups for Resident #1 while the resident was seated at the table. On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not realize that the resident had left two pills on her breakfast plate. Resident #9 then approached the table and picked up the leftover slice of bread that was on the same plate as the two pills. Staff B, unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." A review of Resident #1's Medication Observation Record (MOR) showed 1 milligram and , 5 mg. On at 6:35 A.M., observed Staff B called Resident #1's name to replace the medication that had been left on the plate. On at 6:49 A.M., observed Staff B assisting Resident #6 with the self administration of medications. Staff B placed her ˬ inside the medication bottle, pick up the pill into a disposable cup, and observed the resident swallowing the medication.	A 052		

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A 052	Continued From page 56 A review of facility policy and procedures: assistance with self- administration of medication showed the followings: 4. wash and dry . 6. " the prepared medication directly to the residents to ensure self-administration". 7. "observed and confirm that the resident consumes the entire doses." Wear gloves (not mandatory) before starting the procedure. Staff should use gloves, especially if a pill out of the container. A review of employee record for Staff B showed hired dated , further review showed 6 hours training with assisting with self-administration of medication was received on . Class II	A 052		
A 054 SS=E	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	A 054		

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A 054	Continued From page 57 immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [redacted] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [redacted], 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 observation and record review the facility failed to ensure that it maintained an accurate medication observation record (MOR) for one out of twenty sampled residents (Resident #5). Findings Included: Observation on [redacted] at 6:18 A.M. Staff B (caregiver) called out Resident #5 name to take one of her medications that dropped early. Resident #5 walked to the dining table, Staff B dropped pills into resident [redacted], observed resident swallowing the pills. A review of the Resident #5 medication observation record (MOR's) showed 7:00 A.M. medication Icosepent 1 milligrams (mg) two times a day, [redacted]-10 mg one time a day [redacted] 75 mg and [redacted] 25 mg where not initialed on [redacted] by staff.	A 054		

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A 054	Continued From page 58 A review of the facility policy and procedures assistance with self-administration of medication showed. "document immediately in the MOR, noting date, time, medication name, dosage, method (e.g. crushed in applesauce) and staff initial." Class III	A 054		
A 055 SS=E	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of	A 055		

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A 055	Continued From page 59 physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has	A 055		

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A 055	Continued From page 60 ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and record review and interview, the facility failed to keep medications, both prescription and over the counter, in a locked cabinet or other locked storage receptacle, room, or area at all times. In addition, the facility failed to properly dispose of medication. Findings include: On at 5:48 A.M., observed a room door marked as an office that was unlocked. Inside, a metal cabinet containing a large amount of prescribed medication was also unlocked. On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not	A 055		

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A 055	Continued From page 61 realize that the resident had left two pills on her breakfast plate. Staff B (caregiver), unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." On at 7:00 A.M. observed Staff B removed the plate and disposed of the pills in the trash, stating that she would request replacement pills from the pharmacy and give them the next day. During an interview on at approximately 7:05 A.M., Staff C (caregiver) stated that the usual procedure is to store medications for proper disposal and provide them to the administrator. She added that she believed Staff B was nervous, which was why she threw the pills into the trash can. Class III	A 055		

Agency for Health Care Administration

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A 058 SS=E	429.42( ) FS; 59A-36.023(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 59A-36.023(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 59A-36.008, F.A.C., is documented by agency personnel pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as	A 058		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 058	Continued From page 1 determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of a class I or class II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility is required to employ the consultant services or a licensed registered nurse or pharmacist and a registered dietician to provide onsite quarterly consultations until it is determined that such consultation services are no longer required. The facility had Class II deficiencies regarding medication and dietary services. Findings included:	A 058		

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A 058	Continued From page 2 A) Assistance with self-administration of medication: On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not realize that the resident had left two pills on her breakfast plate. Resident #9 then approached the table and picked up the leftover slice of bread that was on the same plate as the two pills. Staff B, unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." On at 6:49 A.M., Staff B observed assisting Resident #6 with the self-administration of medications. Staff B placed her inside the medication bottle, picked up the pill into a disposable cup, and observed the resident swallowing the medication. B) Medication record: Observation on at 6:18 A.M. Staff B (caregiver) called out Resident #5 name to take one of her medications that dropped early. Resident #5 walked to the dining table, Staff B dropped pills into resident , observed resident swallowing the pills. A review of the Resident #5 medication observation record (MOR's) showed 7:00 A.M. medication Icosepent 1 milligrams (mg) two times a day, -10 mg one time a day 75 mg and 25 mg where not initialed on by staff. C) Medication storage and disposal: On at 5:48 A.M., observed a room door marked as an office that was unlocked. Inside, a metal cabinet containing a large amount	A 058		

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A 058	Continued From page 3 of prescribed medication was also unlocked. On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not realize that the resident had left two pills on her breakfast plate. Staff B (caregiver), unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." On at 7:00 A.M. observed Staff B removed the plate and disposed of the pills in the trash, stating that she would request replacement pills from the pharmacy and give them the next day. During an interview on at approximately 7:05 A.M., Staff C (caregiver) stated that the usual procedure is to store medications for proper disposal and provide them to the administrator. She added that she believed Staff B was nervous, which was why she threw the pills into the trash can. D) Dietary services: On at 7:30 AM, during breakfast, all residents were observed eating a regular diet of two slices of bread, cereal, Ensure, and orange juice. Photographic evidence obtained. On at 7:30 AM, Staff C (Caregiver) stated in an interview that she worked as a cook and also helped residents with self?administration of medications. On at 9:40 AM, when asked whether any residents had special diets, Staff C said there were none. She explained that if a resident did	A 058		

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A 058	Continued From page 4 not like the food, she would make a sandwich instead. When asked about an alternative menu, she said she did not know. A review of records showed that Resident #4's health assessment dated listed a mechanical soft diet with thin fluids. Resident #5's health assessment dated listed a mechanical soft diet, No Concentrated Sweets (NCS), and a diet. Resident #6's health assessment dated listed a diet. Resident #9's health assessment listed an NCS diet. On at 9:54 AM, during an interview, the Administrator was asked for the required six months of original menus but could not find them. A review of facility records showed that the facility did not have any menus from the past six months. Class III	A 058		
A 075 SS=E	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility.	A 075		

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A 075	Continued From page 5 (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and a review of records, the facility failed to have a working automated external defibrillator ( ) on site and failed to ensure that staff were able to operate it. This affected 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included: On at 9:10 AM, the was observed sitting on top of a cabinet in the dining area, making it difficult for staff to reach quickly in an emergency.	A 075		

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A 075	Continued From page 6 On at 9:10 AM, during an interview, Staff C (Caregiver) stated that she did not know how to use the . explaining that she had never been in a situation where it was needed. A review of the pads showed they had an expiration date of . Class III	A 075		
A 077 SS=E	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	A 077		

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	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

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A 077	Continued From page 7 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., 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	A 077		

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A 077	Continued From page 8	A 077		

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.
(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

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A 077	Continued From page 9 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 interviews and a review of records, the facility failed to have a capable administrator to oversee operations, maintain the facility, and ensure appropriate care for all residents. This affected all 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included: On at 9:32 AM, during an interview, the Administrator stated that she did not know how many residents received and said she would need to contact someone else to find out. On at 9:54 AM, the Administrator stated that the facility did not have any residents with special diets and confirmed that they did not have a six month menu with substitutions. On at 10:00 AM, during an interview, the Administrator was asked whether she worked as an administrator in five different locations. She responded, "I do not." A review of the clearinghouse screening management system showed that the Administrator was listed as the administrator in five different facilities and also appeared as an	A 077		

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A 077	Continued From page 10 assistant. Class III	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	A 078		

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A 078	Continued From page 11 education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility , to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and a record review, the facility did not ensure that staff were qualified to perform their assigned duties for 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included:	A 078		

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A 078	Continued From page 12 On at 5:30 AM, Staff D (Caregiver) was observed working alone during the night shift and was responsible for 21 residents. On at 6:30 AM, during an interview, Staff D showed no knowledge of emergency procedures and did not know where residents should go or how they would be evacuated. A review of the Administrator ' s records dated showed that the test results had been overwritten in red and black ink. Class III.	A 078		
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 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	A 083		

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A 083	Continued From page 13 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 interviews and record reviews, the facility failed to ensure that staff were able to how they would perform , , ( ) and First Aid procedures, affecting 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included: On at 6:30 AM, during an interview, Staff D (Caregiver) stated that she had only been in the country for a few months. She did not remember the correct steps for assisting an unresponsive resident. Observation during the interviwed showed Staff D did not know where to put her during , did not know the proper number of , , , did not identify that she would check for a , , and did not say or demonstrate that she would provide breaths. She also stated that if a resident was choking, she would press on the abdomen or hit the resident ' s before calling for help. On at 9:10 AM, during an interview, Staff C explained how she would respond in an emergency. For an unresponsive resident, she said she would start with 60-100 , but did not mention checking for a , first or giving rescue breaths. For a choking resident, she stated she would give blows, place the resident on the floor, and call 911 and the administrator. She added, "I never had this experience before."	A 083		

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A 083	Continued From page 14 A review of records showed that Staff D had valid training through , and Staff C had valid training through . Class III.	A 083		
A 093 SS=E	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed	A 093		

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A 093	Continued From page 15 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide	A 093		

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A 093	Continued From page 16 notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to prepare and serve therapeutic diets as ordered by the health care provider. In addition, the facility failed to substitute menu items with comparable nutritional value and did not keep records of the menu substitutions for	A 093		

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A 093	Continued From page 17 the required six months. These issues affected 3 of 20 sampled residents (Residents #4, #5, and #6). Findings included: On at 7:30 AM, during breakfast, all residents were observed eating a regular diet of two slices of bread, cereal, Ensure, and orange juice. Photographic evidence obtained. On at 7:30 AM, Staff C (Caregiver) stated in an interview that she worked as a cook and also helped residents with self administration of medications. On at 9:40 AM, when asked whether any residents had special diets, Staff C said there were none. She stated that if a resident did not like the food, she would make a sandwich instead. When asked about an alternative menu, she said she did not know. A review of records showed that Resident #4's health assessment dated listed a mechanical soft diet with thin fluids. A review of Resident #5's health assessment dated listed a mechanical soft diet, No Concentrated Sweets (NCS), and a diet. Resident #6's health assessment dated listed a diet. Resident #9's health assessment listed an NCS diet. On at 9:54 AM, during an interview, the Administrator was asked for the required six months of original menus but could not find them. A review of facility records showed that the facility did not have any menus from the prior six	A 093		

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A 093	Continued From page 18 months. Class II	A 093		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use.	A 152		

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A 152	Continued From page 19 (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to Provide a safe living environment free of hazards, ensuring that all exiting architectural, and mechanical structure, are safe for 20 out of 20 sampled residents. (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings Included: Observation on at 5:48 AM showed an unlocked bathroom with cleaning products, bleach, bathroom cleaner, shower cleaner, floor , and other cleaning products. Observation on at 6:10 AM showed the ceiling inside the administrative office was severely cracked and broken. Observation on at 6:30 AM The Common area beside the water fountain, the door was broken at the bottom, pealing and torn off. In an exit conference on 11:52 AM, the Owner stated that he was not aware of the concerns. He said the administrator did not inform about the severe cracks at the facility. Class III	A 152		
A 160 SS=E	59A-36.015(1) FAC Records - Facility	A 160		

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(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 160	Continued From page 20 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

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A 160	Continued From page 21 county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the	A 160		

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A 160	Continued From page 22 last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to keep residents' records securely locked. The facility also failed to ensure that records were accurate and protected from falsification. Findings included: On at 6:00 AM, during a tour of the patio area, unlocked facility records were observed in two closets. These records were accessible to anyone entering the patio area. Photographic evidence was obtained. On at 5:50 AM., the Administrator's office was observed open with unlocked resident records and medications inside.	A 160		

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A 160	Continued From page 23 On at 7:40 AM, Staff B was observed signing the Medication Observation Record (MOR) before providing medications to Residents #4 and Resident #9. On at 8:00 AM, the Administrator was observed telling Staff B that she needed to erase something from the MOR when it was requested for inspection. On at 6:11 AM, Resident #7's bed was observed with a full bed rail attached. Staff B stated that the resident had full bed rails because she could not transfer independently and the rails were used to prevent her from falling. A review of Resident #7's health assessment showed no evidence of a prescription for full bed rails. A review of Resident #1's health assessment dated revealed , , as a diagnosis, but the resident's diet was listed as regular. A review of facility records showed inaccurate admission and discharge logs, with many fields covered in whiteout and overwritten. Class III.	A 160		
A 200 SS=D	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 200		

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A 200	Continued From page 24 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 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	A 200		

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A 200	Continued From page 25 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 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	A 200		

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A 200	Continued From page 26 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 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.	A 200		

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A 200	Continued From page 27 (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 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	A 200		

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A 200	Continued From page 28 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 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	A 200		

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A 200	Continued From page 29 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 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	A 200		

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A 200	Continued From page 30 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 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 reviews, the facility failed to ensure that all staff	A 200		

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A 200	Continued From page 31 were trained to implement emergency management procedures and failed to ensure that it could keep indoor temperatures at or below 81 degrees during an emergency. Findings included: On at 11:10 AM,. A fixed generator was observed in the patio area. On at 11:15 AM., during an interview, Staff C (Caregiver) was asked to turn on the generator. She had difficulty opening the top, and once it was open, she was unable to turn it on. In addition Staff C stated that she believed the generator was diesel-powered but that she was not sure. She also said the generator powered the entire house and that the facility did not have any cooling devices. On at 11:34 AM., during an interview, the Administrator stated that she did not know how much fuel would be needed to keep the generator running for 72 hours during an emergency. When asked about cooling devices, the Administrator said they did not need any because the generator powered the air-conditioning unit. She also did not know that the maximum allowable indoor temperature was 81 degrees Fahrenheit. The Administrator stated that the facility had a fuel contract with the city but could not provide a copy of the contract. A review of facility records showed no evidence of a city fuel contract for the generator. Class III.	A 200		

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A 000	Continued From page 32	A 000		
A 000	Initial Comments A biennial with generator survey was conducted at Adam F/F Inc, on , , . Deficiencies were identified at the time of survey.	A 000		
A 007 SS=G	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least , , . 2. Be free from signs and symptoms of any communicable that is likely tomay be transmitted to other residents or staff. AnHowever, an individual who has , ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. In addition, an individual that exhibits signs or symptoms of or has been diagnosed with a , , illness that can be spread through droplet transmission, may be admitted, at the administrator's discretion, if appropriate droplet precautions are implemented by facility staff. Appropriate droplet precautions include recommendations from nationally accepted standards, recommendations from the local county health department, and the facility's prevention and control policies and procedures at the time of the individual's admission. The individual must otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one	A 007		

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A 007	Continued From page 33 person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a health care practitioner, or a mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 10. Not have any ␣ or 4 , . A resident requiring care of a ␣ , may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to	A 007		

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	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM F/F INC	34 W 14TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 007	Continued From page 34 provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care practitioner; b. The condition is documented in the resident's record and admission and discharge logs; and, c. 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. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or f. Treatment of surgical or , unless the surgical or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. , and , performed in the facility; b. , , performed in the facility. 13. Not require 24-hour nursing supervision,	A 007		

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A 007	Continued From page 35 unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by Section 429.26, F.S.; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable ,,, or assistance with routine , care of site , placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from , with a licensed third party to provide the assistance if	A 007		

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A 007	Continued From page 36 the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) Not withstanding any other provisions of this rule, an individual enrolled in and receiving licensed hospice services may be admitted to an assisted living facility pursuant to Section 429.26(1)(d), F.S. (e) Resident admission criteria for facilities 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, review, and interviews, the facility failed to ensure that one out of twenty sampled residents met admission criteria. Resident #2, who had a , was admitted without ensuring the facility could provide or arrange the necessary services within the scope of his license. Findings include: On at 5:57 A.M., observed Resident #2 in bed with a , bag hanging from the bed. The bag contained dark, bloody liquid. During an interview on at 5:57 A.M. Staff B (caregiver) stated that she emptied the bag for Resident #2 and she did not receive training to do it. A review of the home health agency's patient care order for Resident #2's showed that services included , care by a home health services (HHS) registered nurse (RN), maintaining the , to gravity drainage,	A 007		

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A 007	Continued From page 37 monitoring output, hematuria, patency, and signs of ( ), and providing /, care and irrigation as needed (PRN) for. However, the order was incomplete and the services were not being provided (Photographic evidence obtained). A review of data from Mayo Clinic showed, "A is a medical device that helps drain from your , healthcare provider uses if you have a condition that makes it difficult to pee. Empty your collection bag every two to three hours. If you have a larger collection bag, empty it every eight hours." A review of the home health agency file showed no documentation of service having been provided to Resident #2, and showed no records of the resident's output. A review of the admission procedures, appropriateness of placement and continued residency criteria policies showed: (f). "Assisted living facility staff may provide any nursing services 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 scoop of their professional licensure or training". During a phone interview on at 3:42 P.M., the home health agency [case manager] stated that Resident #2 's care order had been opened the previous day with them, on . He stated that the agency typically provided one or two visits to teach assisted living facility (ALF) staff how to empty the bag. Class II	A 007		

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A 010 SS=D	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, 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	A 010		

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A 010	Continued From page 39 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 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.	A 010		

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A 010	Continued From page 40 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 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	A 010		

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A 010	Continued From page 41 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 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, record review and interview, the facility failed to ensure that one out of 20 sampled residents met the continuing residency criteria (Resident # 7).	A 010		

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A 010	Continued From page 42 Findings included: On at 5:54 A.M., I observed Resident #7 in bed with two bed rails attached, creating a full bed rail. On at 5:55 A.M., Staff B (caregiver) stated that Resident #7 was not receiving hospice care and that the bed rails were used to prevent her from falling out of bed. On at 6:38 A.M. two staff were observed assisting Resident #7 with activities of daily living diapers changes. During an interview at around 6:37 A.M. Staff E (caregiver) stated that Resident #7 was rigid and needed the assistance of two persons. On at 11:59 A.M., observed Resident #7 being spoon fed by Staff E. The resident's , were closed, and were placed on the table. During an interview on at 11;59 A.M., Staff E stated that sometimes Resident #7 ate by herself, but most of the time, when she did not want to eat, that she fed the resident. Staff E also stated, "Today it took us a lot to get her out of bed; she is very rigid." A review of Resident #7's record showed was admitted on , health assessment dated with diagnoses of Type - unspecified , , , ( ), high , , , multifocal . The assessment stated the resident was independent with ambulation and eating, need supervision with toileting and	A 010		

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A 010	Continued From page 43 assistances with bathing, ⎵, self - care and transferring, regular diet and need assistance with self-administration of medications. A review of the admission procedures, appropriateness of placement and continued residency criteria policies showed: 4. (d) "the facility administrator is responsible for monitoring the continued appropriateness of placement of a resident at all the time". 5. Discharge "if the resident no longer meets the criteria for continue residency, or the facility is unable to meet the resident's need, as determined by the facility administrator or healthcare practitioner, the resident must be discharge." Class III	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	A 031		

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A 031	Continued From page 44 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 and response to treatment or services ordered by the physician which may 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,	A 031		

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A 031	Continued From page 45 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 observation, record review, and interview, the facility failed to ensure that a third party home health agency received a complete physician ordered treatment plan for 1 out of twenty sampled residents (Resident #2). Findings include: On at 5:57 A.M., observed Resident #2 in bed with a , bag hanging at the bedside containing dark, bloody liquid. A review of the home health agency's patient care order for Resident #2 showed that services included , care by a home health services (HHS) registered nurse (RN), maintaining the , to gravity drainage, monitoring output, hematuria, patency, and signs of , ( ), and providing , /, care and irrigation as needed PRN for. The order was incomplete. (See photo). During a phone interview on at 3:42 P.M., the home health agency [case manager] stated that the discharge order was not complete and the assisted living facility (ALF) or the resident needed to contact the primary care provider (PCP)or , to determine where and	A 031		

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A 031	Continued From page 46 how often the needed to be changed. Class III	A 031		
A 032 SS=E	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo	A 032		

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A 032	Continued From page 47 identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interviews and a review of records, the facility failed to ensure that staff were knowledgeable about its elopement policies and procedures for 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings included:	A 032		

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	AL11910896	A. BUILDING: _____ B. WING _____	09/10/2026

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A 032	Continued From page 48 On at 9:15 AM, Staff C (Caregiver) stated during an interview that if a resident eloped, she did not mention notifying the resident ' s family. She only said she would call the administrator, call the police, and check the facility. She also did not mention giving the resident ' s photo to the police. On at 9:18 AM, Staff C stated that she had worked at the facility for almost 12 years and had never taken part in an elopement drill. On at 11:45 AM, the Owner stated during an interview that he did not know why staff could not remember participating in elopement drills. A review of the elopement drill log showed that the most recent drill was completed on . Class III	A 032		
A 034 SS=E	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while	A 034		

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A 034	Continued From page 49 rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that residents ' assistive devices were cleaned, kept in good working condition, and free of hazards. Findings included: On at 6:05 AM, during a tour of # , an unclean bath chair with visible rust was observed. This same issue was noted for Residents #7 and #8. On at 6:05 AM, during an interview, Staff E (caregiver) stated that they cleaned bath chairs only once a day. A review of the facility ' s policies and procedures showed that staff were required to clean the bath chair before each use. Class III	A 034		
A 036 SS=F	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	A 036		

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A 036	Continued From page 50 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, and interviews, the facility failed to implement control procedures for 20 of 20 sampled residents (Residents #1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19, 20). Findings Included: 1) Observation on at 6:45 AM showed Staff B (caregiver) passing medications using gloves, then touching surfaces, such as tables, keys and clothing. Further observation revealed she did not sanitize or wash her or consistently change gloves between activities. 2) Observation on at 6:14 AM showed	A 036		

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A 036	Continued From page 51 the residents' bathrooms each had a shower chair, and commode in the shower used by all residents sharing the bathrooms. In an interview conducted on at 6: 16 AM, Staff E who stated the shower chair is clean once per week with bleach and . Class III	A 036		
A 052 SS=G	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	A 052		

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A 052	Continued From page 52 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

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A 052	Continued From page 53 (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , _ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's	A 052		

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A 052	Continued From page 54 health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that trained staff observed residents taking medication. Resident #1 left pills	A 052		

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A 052	Continued From page 55 on her breakfast plate, creating a direct risk to other residents. In addition, the facility staff failed to adhere to the facility's control when assisting one out of twenty sampled residents with self-administration of medication (Resident #6). Findings include: On at 6:21 A.M., observed Staff B (caregiver) punching pills into disposable cups for Resident #1 while the resident was seated at the table. On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not realize that the resident had left two pills on her breakfast plate. Resident #9 then approached the table and picked up the leftover slice of bread that was on the same plate as the two pills. Staff B, unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." A review of Resident #1's Medication Observation Record (MOR) showed 1 milligram and , 5 mg. On at 6:35 A.M., observed Staff B called Resident #1's name to replace the medication that had been left on the plate. On at 6:49 A.M., observed Staff B assisting Resident #6 with the self administration of medications. Staff B placed her ˬ inside the medication bottle, pick up the pill into a disposable cup, and observed the resident swallowing the medication.	A 052		

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A 052	Continued From page 56 A review of facility policy and procedures: assistance with self- administration of medication showed the followings: 4. wash and dry . 6. " the prepared medication directly to the residents to ensure self-administration". 7. "observed and confirm that the resident consumes the entire doses." Wear gloves (not mandatory) before starting the procedure. Staff should use gloves, especially if a pill out of the container. A review of employee record for Staff B showed hired dated , further review showed 6 hours training with assisting with self-administration of medication was received on . Class II	A 052		
A 054 SS=E	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	A 054		

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A 054	Continued From page 57 immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [redacted] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [redacted], 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 observation and record review the facility failed to ensure that it maintained an accurate medication observation record (MOR) for one out of twenty sampled residents (Resident #5). Findings Included: Observation on [redacted] at 6:18 A.M. Staff B (caregiver) called out Resident #5 name to take one of her medications that dropped early. Resident #5 walked to the dining table, Staff B dropped pills into resident [redacted], observed resident swallowing the pills. A review of the Resident #5 medication observation record (MOR's) showed 7:00 A.M. medication Icosepent 1 milligrams (mg) two times a day, [redacted]-10 mg one time a day [redacted] 75 mg and [redacted] 25 mg where not initialed on [redacted] by staff.	A 054		

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A 054	Continued From page 58 A review of the facility policy and procedures assistance with self-administration of medication showed. "document immediately in the MOR, noting date, time, medication name, dosage, method (e.g. crushed in applesauce) and staff initial." Class III	A 054		
A 055 SS=E	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of	A 055		

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A 055	Continued From page 59 physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has	A 055		

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A 055	Continued From page 60 ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and record review and interview, the facility failed to keep medications, both prescription and over the counter, in a locked cabinet or other locked storage receptacle, room, or area at all times. In addition, the facility failed to properly dispose of medication. Findings include: On at 5:48 A.M., observed a room door marked as an office that was unlocked. Inside, a metal cabinet containing a large amount of prescribed medication was also unlocked. On at 6:30 A.M., observed Resident #1 stand up and leave the table. Staff B did not	A 055		

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ADAM F/F INC	34 W 14TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 61 realize that the resident had left two pills on her breakfast plate. Staff B (caregiver), unaware of the pills, took the plate and attempted to dispose of it in a nearby trash can. She was informed that Resident #1 had left two pills on the plate. Staff B stated, "I'm going to replace her medication and call the pharmacy." On at 7:00 A.M. observed Staff B removed the plate and disposed of the pills in the trash, stating that she would request replacement pills from the pharmacy and give them the next day. During an interview on at approximately 7:05 A.M., Staff C (caregiver) stated that the usual procedure is to store medications for proper disposal and provide them to the administrator. She added that she believed Staff B was nervous, which was why she threw the pills into the trash can. Class III	A 055		