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
	AL11969444	A. BUILDING: _____ B. WING _____	03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint #2021001206) and a COVID-19 control survey was conducted at Plaza at Parksquare (The) on to . A deficiency was identifed at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision, and maintain a general awareness of the resident whereabouts for one out of 92 Residents (Resident # 1). Resident #1 eloped from the facility and his whereabouts was unknown for approximately 6 hours. Finding Included: Review of the Agency incident report database showed the facility revealed Resident #1 left the property on at 1:23 PM and was not able	A 025		

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A 025	Continued From page 2 to be located on facility grounds. At 7:55 PM resident returned to the facility. Review of Resident #1 health assessment dated . . . . . showed resident was oriented to person and place and had tendencies of . . . . . and forgetfulness. The resident was not identified as in elopement risk. The resident required assistance with ambulation, bathing, . . eating, grooming, toileting, and transferring. Review of a facility progress note dated revealed, 'Resident #1 eloped and was unable to be located. At 7:55 PM resident returned to the facility'. On at 12:52 PM Resident #1 stated, "I remember going out one night. I want to be able to go out once in a while. I remember I went out and took a long walk. I came . . . in a taxi-cab. I don't remember exactly where I exited the building and I don't remember the address." During an interview on . . . . . at 12:18 PM, The administrator stated Resident #1 left the facility through a side door. He stated the resident eloped because he wanted to go buy a car, which was part of his imagination. The Administrator stated to prevent further elopements, arrangements were made with resident guardian to provide one- to - one supervision. He also stated all the side exit door alarms were reprogrammed to sound when someone open the door and the staff was retrained to respond to the door alarms timely. Class III	A 025		