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
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 #2022001206) was conducted at Hazel Cypen Tower from to . Deficiencies were identified at time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 1 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 as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for seven out of seventy-two sampled residents (Residents #1, #3, #4, #5, #6, #7, #8). The residents sustained ... which resulted in injuries such as ..., ..., and injuries including , (nosebleed). Resident #1 and did not receive assistance for the entire night while sustained ..., an ... at the tip of the left ... bone and an acute through the anterior ... aspect of the C6 ... body. Resident #3 and Resident #7 sustained	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 2 to the after falling. Residents #3, #4, #5, #6 and #8 sustained multiple . Findings included: Review of the facility's log from to showed a total of 36 . Further review showed that 4 residents sustained multiple : Resident #3 sustained 5 , Resident #4 sustained 4 , Resident #5 sustained 4 (2 of them within the same day), Resident #6 sustained 3 and Resident #8 sustained 3 . No prevention was put in place but post intervention. Review of the facility's hospital log showed that 3 residents were transferred to the hospital after falling: Resident #1 sustained closed of bone s/p (status post) , Resident #3 sustained injury s/p (status post) , and Resident #7 was sent to ER (emergency room) for treatment and evaluation of forehead . 1) Review of Resident #1's hospital record received /0222 revealed that Resident #1 was transferred to a local hospital via ambulance on . Resident #1 claimed she was walking during the night, got , forward, and landed on her , Resident #1 also claimed she remained on the floor the entire night without receiving assistance. Further review showed that Resident #1 sustained a tiny at the tip of the left bone and an acute through the anterior aspect of the C6 body (sixth of the ,). Resident #1 was also observed with , (from the). Review of Resident #1's progress notes dated	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 3 ... noted, "Upon arrival to the 5th floor, estimated time was 08:15hrs, this writer was informed that the resident was on the floor. This writer observed [Resident #1] lying down along the side of her bed, noted fresh ... coming from her and on her pillow. When questioned by the MedTech patient stated, "I from the upstairs to downstairs"." Review of Resident #1's health assessment dated ... the resident had medical history and diagnoses of ..., Diastolic ...; the resident had gait ..., hearing ..., and vision ... as physical limitation; the resident required ..., and precautions; the resident needed supervision with ambulation using a wheel walker and needed assistance with eating and transferring. The resident also needed assistance with self-administration of medications. Review of the facility's round sheets showed no round was conducted on the night of to the morning of ... On ..., last round was made to the resident's apartment at 2:59 PM. Interview with Staff I, direct caregiver, on at 9:28 AM, Staff I stated that she found Resident #1 on the floor at around 8:00 AM. She stated that she noticed Resident #1 was ... from the ..., and she did not know when Resident #1 was last seeing during the night. Interview with Staff H, Licensed Practical Nurse (LPN), on at 4:01 PM. Staff H stated, "When I went up there, it was between 8:00 to 8:15 AM. She (Resident #1) was lying on the floor	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 4 down. I noticed fresh coming from her on the floor and on a pillow that was on the floor next to her. That was the first time I saw that patient. I had no idea who worked the previous night." 2) Review of Resident #3's hospital records received showed that Resident #3 was admitted to a local hospital on with chief complaint of injury 3 hours prior arrival to the emergency room. The hospital reported that Resident #3 stated that he was in his usual state of mind while walking in the bedroom. Next thing he remembered was waking up on the floor covered with . Resident #3 was unable to recall how long he was on the floor before calling for help. Review of Resident #3's progress notes showed that Resident #3 sustained 5 from to : Progress notes dated revealed that Resident #3 was found on the floor in his apartment. Resident #3 sustained . Progress notes dated showed that, "At around 4:20 AM call received for nurse to report to resident room upon arrival to the room resident noted in a sitting position in front of his wheelchair by the bed. He stated he slide down from his wheelchair." Progress notes dated revealed, "Around 8:00 AM call received from nurse aide on duty for nurse to report to resident apartment upon arrival resident observed on the floor at bed side in supine position ...Post- Resident was complaining for around his left ."	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 5 Progress notes dated revealed, "Resident observed on the floor by his bed by noon. Resident stated he was getting out of bed by himself to the wheelchair and , denies , and discomfort, moving all extremities without difficulty. As per resident he stated he became , during transfer." Progress notes dated revealed, "Concierge made staff aware that resident called front desk requesting assistance. Upon arrival to resident's apartment resident found inside lying position on the floor, applying pressure to his forehead. Resident obtained a to forehead and is actively . Resident verbalized that his is hurting." Review of Resident #3's health assessment completed on showed medical history and diagnoses of ( ) exacerbation and ( ) exacerbation. Resident #3 needed supervision with ambulation, bathing, , self-care (grooming), toileting, and transferring. 3) Review of Resident #4's progress notes showed Resident #4 sustained 4 within two months period: Progress notes dated revealed, "At 10:40 observed resident on the floor. Denies , and discomfort, moving all extremities without difficulty. Resident was sitting in her wheelchair and tried to go to her big recliner chair" Progress notes revealed, "Resident was observed on the floor in her room in front of her wheelchair on her left side" Progress notes dated revealed, "At 7:10 AM, nurse was made aware by staff while doing morning rounds they observed resident on	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 6 the floor in supine position next to her bed." Progress notes dated revealed, "Around 8:00 AM call received from CNA on duty for nurse to report to resident room. Upon arriving resident observed on the floor in supine position." Review of Resident #4's health assessment completed showed medical history and diagnoses of , due to coronavirus 2019, acute and , failure with , unspecified , uncomplicated , celiac , , unspecified , , , , other fatigue, need for assistance with personal care, unspecified abnormalities of gait and mobility, (generalized), , and , Resident #4 needed assistance with all activities of daily living: ambulation, bathing, , eating, self-care (grooming), toileting, and transferring; and required assistance with self-administration of medication. On at 3:15 PM, during an interview with Staff E (Nurse Program Manager) regarding Resident #4's she stated that her occurred because the resident tried to reposition herself, so they were implementing having her visible, put her in the middle of the bed to sleep and keep checking on her. 4) Review of Resident #5's progress notes showed Resident #5 sustained 4 from to : Progress notes dated revealed, "Around 8:00 AM call received from nurse aid on duty for nurse to report to resident apartment. Upon arrival resident observed on the floor in sitting position her towards her bed on	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 7 the floor, walker at reach room clutter free, resident stated "I was rushing to go to the bathroom, and I slide from the bed to the floor and I couldn't get up"." Progress notes dated revealed, "At 7:20 AM call received from nurse aide on duty for nurse to report to resident room. Upon arriving resident observed in her living room on the floor in supine position bare , the floor wet with , towel on the side and walker at reach, no complaint of , or discomfort voiced. Room was clutter free, resident stated "I was going to the bathroom I slip and "." Progress notes dated revealed, "Around 10:55 AM new call received from nurse aid on duty resident on the bathroom floor. Upon arriving resident observed in sitting position" Progress notes dated revealed, "Around 11:35 AM call received from concierge reporting resident on the floor. Upon arriving resident observed on the floor at bedside in sitting position bare room clutter free, stating "I was trying to change my top I loss my balance and "." Review of Resident #5's health assessment completed showed medical history and diagnoses of , ( ), ( ), low veins, . The physician indicated in the physical or sensory limitations that the resident had difficulty walking. The resident needed supervision with bathing and required medication administration. 5) Review of Resident #6's progress notes showed Resident #6 sustained 3 within one month period: Progress notes dated at 9:35 noted	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 8 that resident was found on the floor in a sitting position against the bathroom wall. The staff stated that resident informed her that she tripped on the way to the closet. Progress notes dated at 4:04 PM noted that resident tried to get out of bed to reach wheelchair and she . The note stated further that the resident was assisted to wheelchair by . Progress notes dated at 3:38 PM showed that resident was trying to get to bed and was too close to the edge and on her . Nurse staff noted that resident was found on floor and able to ambulate afterwards. Review of Resident #6's health assessment completed showed medical history and diagnoses of , Hypertensive , D Deficiency. Special precautions showed resident was a risk. Resident's activities of daily living showed resident needed supervision with eating and self-care, and needed assistance with ambulation, bathing, , toileting and transferring. Resident #6 also needed assistance with self-administration of medication. On at 10:12 AM, Staff C, Quality Assurance Director stated, "For our interventions, you can say it is what we call post interventions. We do post interventions for each resident who ; our nurses do assessment with the residents." 6) Review of Resident #7's progress notes dated at 10:57 PM showed, "Evening shift staff reported, resident was with aggressive behavior came out from his room walking grab	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 9 one of resident hair and rushing to get away he lose his balance and got on the floor bump his right forehead with . . . . . ." However, review of Resident #7's hospital records received showed, "Patient (Resident #7) is coming from a nursing home and as per (Emergency Medical Services) report he was in altercation with another nursing home resident and struck his forehead with the other resident forehead. He now has a cut over the , ." Further review of Resident #7's progress notes indicated that Resident #7 showed signs of instability and aggressive prior to the incident. Progress notes dated at 10:00 AM noted that Resident #7 displayed aggressive behavior towards staff and residents after breakfast; threatening with physical violence and trying to grab staff. The notes also stated, " PRN (Prescribed as Needed) administered, and wife arrived at facility, and he calmed down." Progress notes dated at 02:17 PM revealed, "Resident #7 pacing in the hallway and got easily upset when he was told he could not go into another resident's room. resident was redirected and taken to his room." Review of Resident #7's record showed no health assessment available to reveal his medical history and diagnoses. 7) A review of the log showed Resident # 8 had three (3) . . all in the restroom: . . . . . , . . , and , ... Resident #8's progress notes dated . . . . . stated that resident was found on the floor lying in	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 10 a supine position with . . . elevated on a pillow. The notes further showed that the wife was unable to assist him, and the resident denies , . . There was no documentation that Resident was taken to the hospital for further evaluation. Progress noted stated, "vital signs monitored." A review of the facility's intervention plan for Resident #8 dated . . . . . found the following: The resident is at risk for related to poor safety awareness Goal: Will remain free from major injuries from . . through the next review date Interventions/Tasks: - Check on resident every hours to see if assistance is needed. CNA/LPN - Encourage resident to call for assistance CNA/LPN - Encourage wife and resident to call for assistance as needed. CNA/LPN - Ensure that the call bell is within reach CNA/LPN A review of Resident #8's Health Assessment completed on showed a diagnosis of . . . . . X2 (. . .), , , (. . .), and Mild . . . . . . Resident was noted as a precautions. The activities of daily living showed supervision was needed in . . . . . , and assistance required in ambulation, bathing, eating, self-care, toileting and transferring. Resident needed assistance with self-administration of medication. A review of the facility's . . Prevention Policy revealed that that the purpose was "to assure the safety and well-being of all [facility] residents by identifying risk factors and interventions to reduce the likelihood of . . ." Policy: "It is the policy of [facility] to take steps to reduce the number and	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 025	Continued From page 11 severity of resident . . through appropriate assessment, evaluation, investigation, root cause analysis, identification of risk factors, and interventions that are appropriate for the resident, in order to prevent occurrence, re-occurrence and reduce the likelihood of significant injury. Class II	A 025		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . Hotline,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 12 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 13 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: ____ B. WING ____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 14 representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 15 representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 16 retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible], [illegible] or [illegible], [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to provide safekeeping of funds and prevent fraudulent and [illegible], [illegible] activities for three out of 72 sampled residents (Residents #1, #2, and #21). Two checks for a total amount of $3,100 were cashed from Resident #1 and Resident #2's personal	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 17 bank account in less than two weeks apart. Findings included: Incident 1. Review of Resident #1's record showed that a check for $1,600 reported being cashed from Resident #1's personal bank account on [redacted]. A review of the facility's report regarding the incident showed a check was stolen from the Resident#1's room and cashed on [redacted]. The facility claimed they were not aware of Resident#1 possession of the personal checks. The facility stated that the resident was hospitalized on [redacted] and was discharged on [redacted]; she was readmitted on [redacted] 31, 2022 at the time of the report. For their investigation, the facility noted that they could not make absolute certainty that the theft occurred at the facility, and the incident was "a working assumption only." Review of Resident #1's health assessment dated [redacted] showed that Resident #1, a [redacted] female, had medical history and diagnoses of [redacted], Diastolic [redacted]; Resident Gilbert had gait [redacted], hearing [redacted], and vision [redacted] as physical limitation; the resident required [redacted], and [redacted] precautions; the resident needed assistance with eating, transferring, and self-administration of medications. On [redacted] at 10:46 AM, Director of Risk Management stated, "Resident #1's family member came one day at the business office and told us that a check was cashing under his mother's name. I spoke to the police, to the family, and to the bank. We did not have the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 18	A 030		

authority to pursue the bank to give us the information. They told us only the person or the family can. The family did not even file a police report. We did not even know if she had something like that with her. [The family member] told us it was him who take care of Resident #1's finances. We run the staff records to see who own an account with [the local bank], but the family member did not give us anything to follow through like a check to compare to the account number or the check number that was cashed. We had to stop the investigation because there was nothing else that we could do." Also, when asked if a police report was filed, Director of Risk Management stated, "No. I don't think we have a police report for that. The police officer did not want to take our complaint. He said the family was the one to file the complaint."

However, no staff such as Registered Nurse, Certified Nurse Assistant, or Home Health Agency staff were interviewed regarding the incident, and no residents were made aware to secure their personal properties after the incident.

Incident #2.
Review of Resident #2's record showed that a check for $1,500 was cashed on , , from Resident #2's personal bank account at the same local bank that Resident #1's check was cashed.

Review of the facility's record showed that on , , , Resident #2's family member reported that a check in the amount of $1500 was cashed from Resident #2's account at about . . . . . The family member provided a copy of the canceled check and noted that she had contacted the local bank, the issuing financial institution, and the money was returned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 030	Continued From page 19 to Resident #2's bank account. Based on the facility's investigation report, they contacted the bank where the check was cashed, the family member, and the local law enforcement. However, no staff such as Registered Nurse, Certified Nurse Assistant, or Home Health Agency staff were interviewed regarding the incident, and no residents were made aware to secure their personal properties after the incident. Review of Resident #2's health assessment dated showed that Resident #2, a female had medical history and diagnoses of ( ), , Adjustment , Personal Hx (history) of COVID-19, , Acidosis, , Unspecified Protein-Calorie , Sicca; Physical or sensory Limitations: Abnormal Posture, , Difficulty in walking; or behavioral status: AAOx1; Nursing/Treatment/ service requirements: / ( ); the resident was on risk; the resident needed assistance with ambulation, bathing, toileting, and transferring; the resident needed supervision with eating and self-care; the resident was on calorie controlled diet; the resident needed assistance with self-administration of medications. Class II	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 056	Continued From page 20	A 056		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 056	Continued From page 21 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 056	Continued From page 22 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on interview, observation and record review the facility failed to ensure that one out of seventy-two sampled residents took medications as prescribed (Resident #21). Findings included: On at 11:21 AM, Resident #21 stated that she had not received her morning medications and she had called the front desk for that, but no one had come. On at 11:55 AM, observation showed Staff J (Medication Technician) assisted the resident with self-administration of medications. On at 11:55 AM, Staff J (Medication Technician) stated that Resident #21 did not like to wake-up early, so usually she called when she woke-up and took her medications at approximately 11:00 AM. A review of Resident #21's medication observation record (MOR) revealed the resident had prescribed medications as follow: 9:00 AM - , 500 MG Tab, , P Sol 0.1%, Caltrate 600, Dorzoltimol Sol 22 .8, Gel 0.3%, Hair/Skin/Nails Tab (multiple with), 10MG Tab, , Suc 100MG ER Tab, One Daily Tab	A 056		

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
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 056	Continued From page 23 Women's (with), Rhopressa Sol 0.02%. Class III	A 056		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 162	Continued From page 24 (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ( ), CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a	A 162		

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
	AL11910963	A. BUILDING: ______ B. WING ______	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 162	Continued From page 25 facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [illegible], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 162	Continued From page 26 provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 a Record Review, the facility failed to maintain a complete health assessment for 10 (#3, #5, #7, #21, #37, #41, #42, #43, #54, #56) out of the 72 sampled residents. Findings include: A review of Resident #3's health assessment completed on [redacted] showed that the physical or sensory limitations section was left blank. A review of Resident #5's health assessment completed on [redacted] showed that the special precautions section was left blank. A review of Resident #7's Record found no health assessment in his file. Observation on [redacted] revealed that Staff C obtained a faxed copy of the first page of the resident's health assessment from the pharmacy. A review of page 1 of Resident #7's incomplete Health Assessment showed a diagnosis of Extra nodal Lymphoma (1978), [redacted] Surgery (1986), [redacted] (1993), Angioplasty, Lymphoma [redacted] (2002), [redacted] (2008), Surgery Right [redacted] (2009), Colonoscopy (2011), [redacted] Left Side (2015), [redacted] emergency room (2016), [redacted] (2018),	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 162	Continued From page 27 Angioplasty (2019), Hospital (2021). The sections for " precautions" and "nursing, treatment, including requirements" were left blank. There was no documentation on Resident's #7 activities of daily living nor information on his primary care physician (PCP) and completion date of his health assessment. A review of Resident #21's health assessment completed on showed that the special precautions section was left blank. A review of Resident #37's Health Assessment completed showed that the section for known section was left blank. A review of Resident #41's health assessment completed on showed that the physical or sensory limitations section was left blank. A review of Resident #42's health assessment completed on showed that the nursing/treatment/ service requirements and special precautions sections were left blank. A review of Resident #43's health assessment completed on showed that the nursing/treatment/ service requirements section was left blank. A review of Resident #54's Health Assessment completed showed that the sections for and and nursing/treatment/ service requirements were left blank. A review of Resident #56's Health Assessment completed showed that the section for physical or sensory limitations was left blank.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910963	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 162	Continued From page 28 Interviewed on at 1:50 PM, the Administrator stated, "Someone took it (Health Assessment) out from the file when he went to the hospital, but I will find it today." Interviewed on at 9:48 AM, Staff C stated, "We have to pick it (Health Assessment) up from the doctor's office. We have a problem with the fax, but if it came as an e-mail, we would have it." Interviewed on at 11:02 AM, the Administrator stated, "I have no questions, and I will wait until I receive the report." Class III	A 162		