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 _____	R 08/12/2022

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 Revisit to a Complaint Investigation (complaints # 2022005161 and 2022009263) was conducted at Plaza at ParkSquare from 08/05/2022 to 08/12/2022. Deficiencies were identified at the time of the survey.	{A 000}		
{A 008} SS=F	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made	{A 008}		

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{A 008}	Continued From page 1	{A 008}		

available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further,

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{A 008}	Continued From page 2 Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that,	{A 008}		

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{A 008}	Continued From page 3 in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).	{A 008}		

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{A 008}	Continued From page 4 (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one out of 108 sampled residents (Resident # 116) had a health assessment within 30 days of placement into the facility. Findings included:	{A 008}		

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{A 008}	Continued From page 5 Review of Resident #116's record revealed he was admitted to the facility on . Further review revealed no documentation of a health assessment (AHCA Form 1823). On at 5:05 PM, Staff AE stated the facility spoke with Resident #116's son regarding the health assessment, but they did not receive it yet. Class III	{A 008}		
{A 010} SS=G	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.	{A 010}		

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{A 010}	Continued From page 6 (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 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	{A 010}		

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{A 010}	Continued From page 7 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. 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	{A 010}		

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{A 010}	Continued From page 8	{A 010}		

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 [redacted] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's

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{A 010}	Continued From page 9 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 the appropriateness of continued residency for one out of 119 sampled residents (Resident #1). Findings include: Observation on at 2:33 PM showed resident seated in the living room with an assigned 'sitter' to provider her with one-on-one supervision. A review of the census for the third floor memory care unit where Resident #1 lived was 14 residents. Further review revealed that two dedicated staff were assigned to care for the 14 residents. Further observation at 2:35 pm revealed Resident #1 being held up by two staff members. The resident appeared or sleepy, unable to stand on her own and unable to ambulate from the chair to her walker. After a minute or two, observed Staff sit the resident into the chair. During an interview with the Director of Resident Care, Staff B, on at 2:43 PM, she stated, "[Resident #1] has not been evaluated for continued residency. That is a moment in time. That is not every day with [Resident #1]." A review of the resident and facility records showed that Resident #1 had a history of multiple , some with injuries including black , , and	{A 010}		

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{A 010}	Continued From page 10 at least one of which had lead to hospitalization. Observation on at 4:41 PM revealed Resident #1 in a wheelchair eating with the assistance of a staff member. A review of Resident #1's health assessment dated showed medical diagnoses and a history of , hyperlipemia, , and type 2 . The resident needed supervision with eating, ambulation, transferring, and assistance with bathing, grooming, and toileting. The health assessment indicated that the resident needed no special precautions. On at 4:55 PM, when asked whether the facility had evaluated Resident #1 for the appropriateness of continued residency, Staff AE stated, "Her daughter would not consent for anything. [Resident #1] has durable healthcare power of attorney-no legal guardian. We are issuing her a 45-day notice. On Wednesday, I'm going to have the doctor reevaluate her again based on continued residency. She has demonstrated that she has a history." Class II	{A 010}		
{A 025} SS=H	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 has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to	{A 025}		

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{A 025}	Continued From page 11 such . . . . . or . . . . . . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . . . . . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (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,	{A 025}		

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{A 025}	Continued From page 12 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 care and supervision appropriate to the needs of four of sampled 119 sampled residents to prevent resident resulting in injuries (Resident #10, #19, #72, #83). Findings include: 1) A review of the facility's incident log revealed that Resident #10 two times between through . A review of the facility's incident report dated showed at 2 PM, Resident #10 was found on the floor. A review of the facility's post- policy and procedures showed the facility "document in the Resident's service notes any information about the incident." A review of Resident #10's progress notes showed no documentation of the Resident's . A review of Resident #10's health assessment dated showed medical diagnoses and a history of of orbital floor, of bones, , Type 2, unspecified , , ,	{A 025}		

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{A 025}	Continued From page 13 , and major . The Resident needed supervision with ambulation and assistance with bathing, , toileting, and transferring. The health assessment indicated that the Resident needed precautions. 2) A review of the facility's incident report dated showed at 2:30 AM, "Wife called to say [Resident #19] was on the floor. 911 called; Resident refused." A review of Resident #19's progress notes dated showed, "Resident presented large to the left arm. Home health cleaned and dressed area." During an interview on at 4:30 PM, Resident #19's wife stated, "My husband went to the bathroom, and when he was coming from the bathroom, he . He was on the floor, and the Certified Nursing Assistant (CNA) told me she had to go get somebody else because she did not know what to do. They came like 30 minutes later. That was when they finally called 911. He was on his arm." In an interview with Resident #18 and #19's daughter on at 5:38 PM, "The staff didn't know what to do. It took another 30 minutes for the staff to come with another staff and it took about 20 more minutes before 911 came here. Nobody tried to help my father get off the floor. He went over one hour on the floor. Today was the first time he received nurse care from home health. Imagine if my father hit his and was on the floor . He would have , there on the floor." A review of Resident #19's health assessment	{A 025}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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{A 025}	Continued From page 14 dated . . . . . showed medical diagnoses and a history of muscular . . . . . prior . . . . . sleep . . . , and . . . . . The Resident needed supervision with ambulation and grooming and assistance with bathing, . . . toileting, and transferring. The health assessment indicated that the Resident needed precautions. 3) A review of the facility's incident report dated . . . . . at 8:40 PM, Resident #72 was found on the floor crying of . . . to the right . . . and . . . . 911 was called; however, the Resident refused to go to the hospital. A review of Resident #72's progress notes dated . . . /20222 showed, "Staff reported Resident inside her living room. Complained . . . in the right . . . and right . . . 911 was called, assessed the Resident, and left her in the facility. Suggested . . . Used ice to . . . / . . . area. Refuses to see the doctor today and refuses an . . . ." A review of Resident #72's health assessment dated . . . . . showed medical diagnoses and a history of . . . right . . . . . , and . . . . . The Resident needed assistance with ambulation, bathing, . . . grooming, toileting, and transferring. The health assessment indicated that the Resident had no precautions. A review of Resident #72's records showed no documentation of the Resident being reassessed after her . . . 4) A review of the facility's incident log revealed that Resident #83 two times in .	{A 025}		

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{A 025}	Continued From page 15 A review of the facility incident report dated ..... showed that Resident #83 was found on the floor. When asked how she , the Resident stated she was getting in bed and slid to the floor. A review of the facility's post- policy and procedures showed the facility "document in the Resident's service notes any information about the incident." A review of Resident #83's progress notes showed no documentation of the Resident's . A review of Resident #83's health assessment dated ..... showed medical diagnoses and a history of , , , , left , , 's ....., and ..... , . The Resident was independent with ....., eating, and grooming and needed assistance with ambulation, bathing, toileting, and transferring. The health assessment indicated that the Resident needed precautions. In an interview with the administrator on ..... at 11:31 AM, she stated, "During the admission process, the initial assessment is done to determine what type of assistance the resident needs. If the Resident needs more assistance, a care plan meeting is done with the family. The initial assessment and care plan are documented in the Resident's file. " Record review of the residents who have . at the facility showed no documentation of an initial assessment or a care plan. A review of the facility's records showed no documentation of a . prevention policy.	{A 025}		

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{A 025}	Continued From page 16 In an interview on [redacted] at 6:45 PM, Staff AE stated regarding preventive measures for residents with [redacted], "it's a work in progress. The consultant is coming on the 1st to assist with that. " Uncorrected Class II	{A 025}		
{A 030} SS=K	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; [redacted], Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida [redacted] Hotline,	{A 030}		

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{A 030}	Continued From page 17 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}		

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{A 030}	Continued From page 18 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}		

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{A 030}	Continued From page 19	{A 030}		

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

Agency for Health Care Administration

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{A 030}	Continued From page 20	{A 030}		

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

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{A 030}	Continued From page 21 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 . . . . Hotline operated by the Department of Children and Families, and , 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 . . . , . . . or . . . , ... 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 review and interview, the facility failed to honor the resident's right to receive adequate and appropriate health care for one out of 108 sampled residents (Resident #66). Resident #66 became unresponsive, then . Four facility staff were present at various times during the episode, but	{A 030}		

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{A 030}	Continued From page 22 they did not intervene or perform , , ( ) for 12 minutes. The facility also failed to honor resident rights to be treated with consideration and respect and with due recognition of personal dignity. Resident #9 was observed tied to a wheelchair with a blanket (photographic evidence obtained). Findings included: Event 1. Review of the facility's incident report dated ..... showed paramedics pronounced Resident #66 on (no time provided). The report also indicated on (no time provided) that Resident #66 was with a Private Duty Aide (PDA) when the facility staff heard a scream and went to investigate. The report further noted that the facility staff found the resident, who was "breathing different," (sic) and the staff called 911 (no time provided). During an interview with the resident's PDA on ..... at 3:11 PM, the PDA stated that she never screamed, but she pressed the call light and ....., initiated a call to the resident's son, since the staff usually took a long time to respond to call lights. Review of the call light log dated ..... showed Resident #66's pendant was pressed at 08:35 AM. A review of the emergency services ambulance run record dated ..... showed that rescue was dispatched on ..... at 08:44 AM and arrived at in resident apartment at 08:49 AM. The report noted, " (patient) not alert in bathroom, last seen about an hour ago." The report further	{A 030}		

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{A 030}	Continued From page 23 documented that the resident was at the scene and staff told rescue personnel that the resident was last seen about an hour earlier when they were trying to give the resident medications. During an interview with Resident #66's private duty aide on at 11:17 AM, PDA stated that Resident #66 had 24 hours, 7 days week private aides on duty. She further stated the morning of the incident, she arrived at the facility at around 07:00 AM and never left the room. Review of Resident #66's health assessment completed on showed the resident had medical history and diagnoses that included , and ( ). The resident was independent in ambulation, eating, grooming, toileting, and transferring. The Resident needed assistance with bathing, and self-administration of medications. Resident #66 did not have a signed ( ) in her file. While no policy was in place, a review of the facility's procedures revealed, "A trained staff will honor the in the following manner: If the resident is found absent of , or , and there is no licensed nurse or physician in the building call 911. Check the record for paperwork. Initiate if no is found including the use of [Automated External Defibrillator]." Further review of the incident report showed that the administrator wrote, "before resident went limp, she was on her chair, they were transferring her to her shower chair by private duty aide. was initiated by facility staff. No on records." However, all staff denied providing .	{A 030}		

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{A 030}	Continued From page 24 On . . . . . at 12:00 PM, Staff Y (Medication Technician (Med Tech)/Shift Leader) stated that on . . . . . she received a call from the facility's walkie-talkie to report to the 7th floor, where Resident #66 lived. She stated that upon arrival at the resident's apartment, she observed Staff L (Direct Caregiver) and Staff P (Med Tech/Direct Caregiver) holding the resident while the resident was sitting on the toilet. Staff Y reported then stated that she went to the 2nd floor, called 911, and returned to the resident's apartment. When she arrived at the apartment, she saw the resident was on the floor and unresponsive. Staff Y further stated that there were 3 staff (Staff L, Staff P, and Staff W) present inside the room, so she left not providing . On at 12:04 PM, Staff W (Med Tech/Direct Caregiver) stated that she did not remember if was given to the resident. She stated that the resident did not have a . . She also stated that she left the apartment before 911 arrived, and she did "not perform any . on anybody". On at 12:08 PM, Staff P (Med Tech/Direct Caregiver) stated that she heard a scream that day. Staff P stated that she went into Resident #66's apartment after she saw Staff L enter. Staff P stated that she observed the resident was naked sitting on the toilet with the PDA by the resident's side, and the resident was "changing color." Staff P reported that, by the time they put the resident on the floor, the resident had completely passed out. Staff P that she and the PDA tried to put some clothes on the resident before 911 came and stayed by the resident until 911 came. Staff P reported that she could not remember if any of the staff had performed on the resident. Staff P stated	{A 030}		

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{A 030}	Continued From page 25 that she did not perform . on Resident # 66 and did not know if the resident had a . On at 12:20 PM, Staff L (Direct Caregiver) stated that she heard a scream coming from the resident's apartment and she went inside the apartment to investigate. The resident was found sitting on the toilet while the PDA was crying. Staff L stated that she left the room before 911 came. Staff L also stated that she did not perform . and did not know if the resident had a . . On at 12:35 PM, Staff B (Director of Resident Care) stated that Resident #66 did not have a . Resident #66 never had a executed even though during the admission the resident's demographic sheet had a checked box indicating that the resident had a . . On . . . . . at 11:28 AM, Staff Y was interviewed regarding her role during the incident, Staff Y (Med Tech/Shift Leader) stated, "When I got to the resident's room, I saw Staff P and Staff L were there. I left and went downstairs to call 911. I was on the 2nd floor when I was looking at the resident's file. No, she didn't have a ( ) order. I looked in the book and saw her name was not on the list. We have a book that tells us who has a . No Resident #66 did not have a . ." When asked if any of the staff performed , Staff Y stated, "No, they were about to, but the paramedics came. I announced it over the radio that the resident did not have a . . . I was asking them to go get the defibrillator upstairs, but they did not respond. Since they did not respond, I went to go get it myself. Yes, I asked them to start performing . . No, I did not perform because when I came with the	{A 030}		

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 030}	Continued From page 26 defibrillator, rescue was already in the room." When asked if the resident had the yellow dot (yellow dot is a visual aide to identify) on her apartment's door, Staff Y stated, "No. There was no yellow dot on her door." During an interview with Director of Resident care on at 03:22 PM regarding the 'yellow dots' on the residents' apartment doors implemented as a visual aide to assist staff in rapidly identifying residents who had a , the Director of Resident Care stated, "The yellow dot was implemented like 2 weeks before the incident with [Resident # 66] happened." The director of resident care then stated, "Staff were trained on the yellow dots, and they were told what they meant. We have a book that has all the people listed for . Yes, the staff were told where to look for the book if they need it." When asked why was not performed on Resident #66 while the resident did not have a order, the Director of Resident Care stated, "I wasn't there. What does one have to do with the other? I can't tell you that. [Administrator] was the one the staff called. I don't know if they did not perform ." When asked if she investigated whether the staff performed , Director of Resident Care stated, "No. Ask [Administrator]." A review of the facility's video footage for the date of the incident showed Staff L, Staff P, Staff W, and Staff Y went in and out of Resident #66's apartment from 08:37 AM to 08:49 AM, a total of 12 minutes. Further review of the video footage showed that Staff Y brought the Automated External Defibrillator ( ) to Resident # 66's unit at 8:52 AM, after Emergency Medical Services were already onsite. According to the American Red Cross, "An ,	{A 030}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 030}	Continued From page 27 or automated external defibrillator, is used to help those experiencing sudden . It's a sophisticated, yet easy-to-use, medical device that can analyze the 's rhythm and, if necessary, deliver an electrical , or , to help the re-establish an effective rhythm." According to the American Association (AHA) updated guidelines 2020 for and First Aid, " - or , , , - is an emergency lifesaving procedure performed when the stops beating. Immediate can double or triple chances of survival after . We recommend initiate for presumed because the risk of harm to the patient is low if the patient is not in ." Event 2. During a moratorium monitoring on at 09:30 AM, observation showed Resident #9 seated at the dining table in the memory care unit, eating breakfast. The resident was tied to a wheelchair with a sheet which had been placed by her private duty aide. Also observed two caregivers and one Med Tech caring for 14 residents. On at 09:30 AM, when asked why the resident was tied to the wheelchair, the PDA stated that she was afraid that the resident (Resident #9), who had a history of , would lean forward, and out of the chair. The PDA stated that she worked in hospitals and that this was done in those settings. The PDA stated that she did not know if the resident was prescribed a or whether the resident had a plan of care for .	{A 030}		

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{A 030}	Continued From page 28 Review of Resident #9's progress notes dated revealed, "staff reported that resident was being restrained with a blanket by her PDA. Upon discussion with PDA, she stated that "I have worked in nursing homes, hospitals and that's what they do for her safety." Review of Resident #9's health assessment dated showed medical history that included but was not limited to diagnoses of , , ( ), and . The resident used a walker and wheelchair to ambulate. The resident needed precautions. The resident needed supervision with eating, and needed assistance with ambulation, , toileting, and transferring. The resident needed total care with bathing and self-care (grooming). The resident also needed assistance with self-administration of medications. During an interview on at 09:35 AM, the Director of Resident Care stated that she was not aware that the PDA was tying the resident to the wheelchair, and that the aide was filling in. When asked whether orientation or training was provided to private aides to ensure that they were aware that residents could not be tied and could not otherwise be restrained unless there was consent, medical review, and a plan of care, she stated that she didn't think so, although the facility staff had been retrained. Uncorrected	{A 030}		

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{A 030}	Continued From page 29 Class I	{A 030}		
{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 identification upon admission or upon being assessed at risk for elopement subsequent to	{A 032}		

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{A 032}	Continued From page 30 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 record review and interview, the facility failed to follow its policies and procedures regarding elopement after two of 119 sampled residents (Residents #33 and 116) left the facility without staff knowledge. Findings include: 1) A review of facility records revealed an incident report dated showed that Resident #33 went through the front door (lobby) and went	{A 032}		

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{A 032}	Continued From page 31 on the busy street. Then, a staff member went after the resident and caught her at the time when Resident #33 was stepping right into a moving car. A review of Resident #33's health assessment completed on [redacted] showed medical history and diagnosis of [redacted] without behavioral disturbance and [redacted]. The [redacted] or behavioral status section showed the resident had a moderate [redacted]. Resident #33 was identified as not at risk for elopement. The resident needed assistance with the self-administration of medication. On [redacted] at 10:57 AM, the Administrator stated that she heard about Resident #33 [redacted] in the building, but that happened before she began working at the facility. When asked when she started working at the facility, the Administrator stated that she began on [redacted]. Per facility records, the incident occurred on [redacted]. A review of the resident record on [redacted] revealed there was still no documentation of the incident. Further review of the resident's record revealed there was no documentation that the resident received a medical evaluation or care. There was no documentation of an updated health assessment. There were no documented elopement precautions put in place for the resident. A review of Resident #116's record revealed the following progress notes dated [redacted]: "Staff reported approximately 6:37 AM she found resident [redacted] outside the staff entrance of	{A 032}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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{A 032}	Continued From page 32 the building. She stated he seemed very and didn't know where he was going. Staff directed the resident to wellness, and he was escorted to his room by Staff. Further review showed no documentation of Resident #116 health assessment. On at 10:57 AM, the Administrator stated that after an elopement, the physician would come to the facility to evaluate the resident. A review of the resident record on revealed there was still no documentation that the resident received a medical evaluation or care. There was no documentation of an updated health assessment. There were no documented elopement precautions put in place for the resident. Review of the facility's elopement policies and procedures stated "When a resident is located and returned: document or instruct the staff to document the resident's disappearance in the resident's progress notes. After the elopement, the Executive director or supervisor on site will evaluate the resident's needs and continued residency. Consideration by the physician should be requested regarding the need for medical or re-evalutation." Review of the facility's elopement policies and procedures stated "A binder will be kept at the front desk with information to identify resident's that are at risk for elopement. During an interview on the Corporate staff (Staff AE) stated "They don't have a list of the residents who are an elopement risk."	{A 032}		

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{A 032}	Continued From page 33 Uncorrected Class III	{A 032}		
{A 033} SS=F	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that resident's had a written care plan for the use of physical (bed rails) for two out of 119 sampled residents (Resident #81, and Resident #104).	{A 033}		

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{A 033}	Continued From page 34 Findings Included: Observation on at 2:42 PM revealed Resident #81 in bed with full bed rails. Review of Resident #88's record revealed no documentation that a care plan was implemented for the use of the . Observation on at 2:58 PM revealed Resident #104 in bed with two half bed rails Review of Resident #104's record revealed no documentation that a care plan was implement for the use of the . During an interview on at 5 PM Corporate staff (Staff AE) stated "No one here has a full bed rail anymore." Uncorrected Class III	{A 033}		
{A 034} SS=F	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	{A 034}		

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{A 034}	Continued From page 35 record. (c) Direct care staff using assistive devices while 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, interview and record review, the facility failed to ensure they documented each assistive device a resident uses in the resident record for five out of 119 sampled residents (Resident#3, #58, #60, #97 and Resident #108). Findings included: Observation on . . . . . at 3:05 PM revealed Resident #3 sitting in a wheelchair. Observation on at 7:40 AM revealed Resident #97 ambulating with a rolling walker. Review of the facility's assistive device inspection list revealed Resident #108 had a wheelchair check up on . . . . . . Review of the facility's assistive device inspection list revealed Resident #58 utilized a walker and wheelchair. Further review revealed Resident #60 utilized a walker. Review of Resident #3, #58, #60, #97 and Resident #108's record revealed no documentation of each assistive device a resident uses included in their resident record.	{A 034}		

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 034}	Continued From page 36 During an interview on [redacted] at 4:52 PM, Corporate staff (Staff AE) stated "We are still working on this." Uncorrected Class III	{A 034}		
{A 053} SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including [redacted] testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if	{A 053}		

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 053}	Continued From page 37 facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a license nurse for the administration of medications for one out of 119 sampled residents (Resident #6). Finding include: A review of Resident #6's Health Assessment dated . . . . . showed that the resident required medication administration. A review of Resident # , Medication Observation Record (MOR) on . . . . . showed that the medications were provided by non-license nursing staff such as medication technicians. In an interview with Staff AH on at 4:37 PM, the staff member stated that "I gave Resident #6 her medications". Staff AH is a non-license nurse. She is a medication technician. Uncorrected Class III	{A 053}		
{A 054} SS=H	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS.	{A 054}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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{A 054}	Continued From page 38 (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] 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 [illegible], 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 record review and interview, the facility failed to maintain an accurate and up to date Medication Observation Record (MOR) for one out of 119 sample residents (Resident #110). Finding include:	{A 054}		

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 054}	Continued From page 39 A review of Resident #110 Health Assessment dated , it showed that the resident has a medical history and diagnosis of , , , and now status post , , since . The resident was independent with eating, self-care, and toileting, and needed supervision with bathing, , and transferring. He needed assistance with ambulation. As for medication, the resident needs assistance with self-administration of medications. A review of Resident #110's , Medication Observation Record (MOR) showed that the medication technicians were not updating and signing the MOR. The staff was following a medication list provide by Resident #110 and not the medications listed in electronic medication observation record. A review of Resident #110's MOR showed that the medication technicians were not updating and signing the MOR. The staff was following a medication list provide by Resident #110 and not the medications listed in the electronic medication observation record. In an interview on at 9:28 AM, Staff P stated she provided the medications to the resident. Staff P had a copy of the medication list in the medication cart. Staff P stated, "I followed the medication list. The MOR is confusing". The resident received all his morning medications. Uncorrected Class III	{A 054}		

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

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A 058	Continued From page 40	A 058		
A 058 SS=E	429.42(.) FS; 58A-5.033(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. 58A-5.033(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 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist	A 058		

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 _____	R 08/12/2022

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

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A 058	Continued From page 41 licensed pursuant to Section 465.0125, F.S., or registered nurse as 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 the class I or 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 record review and interview, the facility is required to employ the consultant services or a licensed registered nurse who will, at a minimum, provide onsite quarterly consultations until an inspection by the Agency's personnel determines that such consultation services are no longer required. The facility received a Class II on the deficient practice of Medication- Records for writing the wrong medical order for Resident #110 and an uncorrected Class III deficient practice of Medication- Administration for unlicensed staff administering medication to Resident #6.	A 058		

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 _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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A 058	Continued From page 42 Finding Include: A. A review of Resident #110's Physician Order dated , it showed that the resident had a medical order for , 10 mg take one tablet once daily on Monday, Wednesday, and Friday ( ). A review of Resident #110's Medication Observation Record on , it showed that , 10 mg has been given twice a day at 8:00 AM and 5:00 PM. In an interview B on at 10:45 AM, Staff B stated that she did not know anything about it. A review of Resident #110's and Medication Observation Record, it showed that the medication technicians were not updating and signing the medication record. The staff was following a medication list provided by the resident and not the medications listed in the Medication Observation Record. In an interview on at 9:28 AM, Staff P stated that "I followed the resident medication list. The Medication Observation Record is confusing". B. A review of Resident #6's Health Assessment dated showed that the resident required medication administration. A review of Resident #6's Medication Observation Record on showed that the resident medications were provided by the	A 058		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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A 058	Continued From page 43 medication technicians. The technicians are not licensed nurses. In an interview with Staff W on at 10:10 AM, Staff W stated that she gave Resident #6 her medications. A review of Resident # , Medication Observation Record on ..., it showed that the medications were provided to the resident by non-license nursing staff. The Health Assessment still indicated that the resident required medication administration. In an interview with Staff AH on ... at 4:37 PM, Staff AH stated that "I gave Resident #6 her medications". Staff AH is a non-license nurse. Class III	A 058		
{A 077} SS=I	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	{A 077}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 077}	Continued From page 44	{A 077}		

test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.
(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

59A-36.010
(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.
(a) An administrator must:
1. Be at least [illegible];
2. If employed on or after [illegible], 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 [illegible], 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.

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

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{A 077}	Continued From page 45 Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the . . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (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 ,	{A 077}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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

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{A 077}	Continued From page 46 20, 1998, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that it was under the supervision of a qualified Administrator for more than 120 consecutive days. The Administrator, who was certified prior to the CORE training and certification examination failed to maintain continuing education requirements. Findings Included: 1) A review of the facility's roster on the Background Screening Clearing House database showed that the Administrator was hired on . A review of the Administrator's records showed a hire date of and a CORE training certificate dated . Further review showed no documentation that the Administrator had taken the CORE competency test, such as a	{A 077}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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

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{A 077}	Continued From page 47 CORE identification card. The Administrator will be required to retake the CORE and pass the test. During an interview on [redacted] at 1:24PM the Administrator stated "I have completed the 26 hour training, I have the test scheduled for the 26th." Uncorrected Class II	{A 077}		
{A 078} SS=I	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 [redacted]. 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 [redacted] 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 [redacted] testing materials satisfies the annual [redacted] examination requirement. An individual with a positive [redacted] test must submit a health care provider's statement that the individual does not constitute a risk of [redacted]. 2. If any staff member has, or is suspected of	{A 078}		

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

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{A 078}	Continued From page 48 having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. 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:	{A 078}		

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{A 078}	Continued From page 49 Based on record review and interview, the facility failed to ensure that four staff members (Staff L, Staff P, Staff W, and Staff Y) were able to exercise their responsibilities, consistent with their qualifications to perform their assigned duties consistent with their level of education, training, preparation, and experience in accordance with staff roles relating to emergency preparedness. All four staff failed to perform , , , ( ) on a resident (Resident #66) who became unresponsive and did not have a ( ). Findings included: Review of the facility's adverse incident report showed, "Resident was with PDA when the MedTech heard a scream and went to see what was going on. The PDA told the MedTech that she went limp, and she was breathing different. They called the shift lead Staff Y who assisted as MedTech called 911. the paramedics came and pronounced the time of ." Further review of the incident report showed that the administrator reported, "before resident went limp, she was on her chair, they were transferring her to her shower chair. by private duty aid. was initiated by facility staff. No on records." However, interview with all four staff who were present during the incident denied performing . On at 12:04 PM, Staff W (Med Tech/Direct Caregiver) stated that she did not remember if was given to the resident. She stated that the resident did not have a . She also stated that she left the apartment before 911 arrived, and she did "not perform any on	{A 078}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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

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{A 078}	Continued From page 50 anybody". On . . . . . at 12:08 PM, Staff P (Med Tech/Direct Caregiver) stated that she heard a scream that day. She stated that she went inside the Resident #66's apartment after she saw Staff L went inside the apartment. She stated that she found the resident sitting on the toilet with the PDA (private duty aide) by the resident's side. She stated that she saw the resident was changing color, and the resident was naked. She stated by the time to put the resident on the floor, the resident was completely passed out. She stated that they tried to put some clothes on the residents before 911 came. She stated that she stayed by the resident until 911 came, but she could not remember if any staff performed on the resident. She also stated that she did not perform . and did not know if the resident had a . On at 12:20 PM, Staff L (Direct Caregiver) stated that she heard a scream coming from the resident's apartment and she went inside the apartment to investigate. She stated she found the resident sitting on the toilet while the PDA was crying. She stated that she left the room before 911 came. She also stated that she did not perform . and did not know if the resident had a . Interview with Staff Y (Med Tech/Shift Leader) on . . . . . at 11 28 AM regarding her role during the incident, Staff Y stated, "When I got to the resident room, I saw Staff P and Staff L were there. I left and went downstairs to call 911. I was on the 2nd floor when I was looking at the resident's file. No, she didn't have a order. I looked in the book and saw her name was not on the list. We have a book that tells us	{A 078}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 078}	Continued From page 51	{A 078}		

who has a . No Resident #66 did not have a ." When asked if any of the staff conducted , Staff Y stated, "No, they were about to, but the paramedics came. I announced it over the radio that the resident did not have a . I was asking them to go get the defibrillator upstairs, but they did not respond. Since they did not respond, I went to go get it myself. No, I did not perform because when I came with the defibrillator rescue was already in the room." When asked if the resident had the yellow dot on her apartment's door, Staff Y stated, "No. There was no yellow dot on her door."

During an interview with Director of Resident care on at 03:22 PM regarding the yellow dots' implementation for on the residents' apartment doors, Director of Resident Care stated, "The yellow dot was implemented like 2 weeks before the incident with Resident #66 happened." The director of resident care then stated, "Staff were trained on the yellow dots, and they were told what they meant. We have a book that have all the people listed for . Yes, the staff were told where to look for the book if they need it." When asked why was not performed on Resident #66 while the resident did not have a order, the director of resident care stated, "I wasn't there. What one has to do with the other. I can't tell you that. [administrator] was the one the staff called. I don't know if they did not perform ." When asked if she investigated whether or not the staff performed , Director of Resident Care stated, "No. Asked [Administrator]."

A review of the facility's video footage from the date of the incident showed that staff spent around 12 minutes going inside and out of

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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 078}	Continued From page 52 Resident #66's apartment but did not intervene to perform : At 08:37 AM, Staff L (Direct Caretaker) exited the elevator and entered Resident #66's apartment At 08:39 AM, Staff W (Med Tech/Direct Caretaker) and Staff Y (Med Tech/Shift Leader) exited the elevator and entered Resident #66's apartment with Staff W carrying an item resembling a [illegible] machine. At 08:40 AM, Staff Y exited Resident #66's apartment and entered the elevator. At 08:41 AM, Staff W rushed out of Resident #66's apartment to go to the elevator, but she did not get inside the elevator. Staff W was observed to use an item to talk resembling a walkie talkie, then she went to Resident #66's apartment. At 08:43 AM, Staff L exited Resident #66's apartment and pacing and forth outside the apartment. At 08:45 AM, Staff P, Staff Y, and home health Nurse exited the elevator and entered Resident #66's apartment. At 08:46 AM, Staff Y and Home Health Nurse exited Resident #66's apartment and entered the elevator. At 08:46 AM, Staff W rushed out Resident #66's apartment and asked Home Health Nurse to return to the resident's apartment. At 08:49 AM, [illegible] exited the elevator and entered Resident #66's apartment. Review of Staff L's record showed that Staff L completed the [illegible] and first Aid training on [illegible], and the and first Aid training is valid for 2 years. Review of Staff P's record showed that Staff L completed the and first Aid training on [illegible], and the [illegible] and first Aid training is valid for 2 years.	{A 078}		

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 _____	R 08/12/2022

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 078}	Continued From page 53 Review of Staff W's record showed that Staff W completed the . and first Aid training on , and the . and first Aid training is valid for 2 years. Review of Staff Y's record showed that Staff Y completed the and first Aid training on , and the . and first Aid training is valid for 2 years. A review of the facility's and First Aid policies was not conducted since the policies were never received. Uncorrected Class II	{A 078}		
{A 079} SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539	{A 079}		

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 _____	R 08/12/2022

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 079}	Continued From page 54 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be	{A 079}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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{A 079}	Continued From page 55 physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the	{A 079}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 079}	Continued From page 56 requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.	{A 079}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 079}	Continued From page 57 (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that enough qualified staff were available to provide resident supervision and to provide or arrange for resident care in accordance with residents scheduled and unscheduled service needs. A total of 479 calls were left unanswered for 30 minutes of more within a period of 44 days. Findings include: 1) In an interview on at 4:30 PM, Resident #18 stated, "My husband . last Monday. I pressed the pendant, but nobody came until 25 minutes later. Last Wednesday, my husband wanted to get a shower, but nobody came to shower him. They don't shower him on Wednesday and Saturday. They don't have any nurses here." In an interview with Resident #18 and #19's daughter on at 5:38 PM, she stated, ". My father . My mom told me it took 20 minutes for the staff to come. They only had four staff that night for like 100-something residents. That's what [Staff B] told me. They only had four staff that night. They have no nurses, and they are under staff. I am not happy with the situation at all." A review of the facility's call light logs from - showed that Residents #18 and #19 called	{A 079}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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{A 079}	Continued From page 58 for assistance over 6 times, with calls times ranging from 50 minutes to 11 hours and 44 minutes: . . . . . lasting over 11 hours (hr.) and 44 minutes (mins.), last over 57 mins., ... last over 59 mins., ... last over 1 hr. and 38 mins., last over 1 hr. and 24 mins., and . . . . . last over 50 mins. A review of Resident #19's health assessment dated . . . . . showed medical diagnoses and a history of , , , advanced . . . . . , gait ataxia, ... , dry , , , and . . . . . The resident was independent with ambulation, eating, and grooming and needed supervision with bathing, , toileting, and transferring. 2) A review of the adverse incident report filed on . . . . . showed during the morning shift, the MedTech (Medication Technician) on duty heard a scream come from . . . . . When she went to investigate, she was told by Resident #66's private duty aide that the resident "went limp and was breathing differently." The MedTech then contacted the shift lead, who assisted in calling 911. When paramedics arrived, the resident was pronounced . . . . . In an interview on . . . . . at 3:11 PM, Resident #66's private duty aide stated, "I woke her up at 8:00 AM. I let her sit on the bed before I could take her to the shower. From 08:12 to 08:13 AM, I put her on the toilet and started to shower her. Right away, I saw she had fainted. I took the pendant and started pressing it. While I was pressing the button, I called her son and told the son that her mom was limping. I asked him to call the facility to ask them to come faster	{A 079}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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

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{A 079}	Continued From page 59 because sometimes they don't come to the room fast." A review of the facility's call lights log showed on [redacted] at 8:35 AM that Resident #87's call light lasted over 3 hr. and 36 mins. A review of Resident #66's health assessment dated [redacted] showed medical diagnoses and a history of [redacted]. The resident was independent with ambulation, eating, grooming, toileting, and transferring and needed assistance with bathing and [redacted]. 3) During an interview on [redacted] at 7:50 AM, Resident #87 stated, "Yes, I call for help, but they don't come. It takes them a long time to come. I have to go to my [redacted] I need them to help me now, but they don't come." In an interview with Resident #87's son on [redacted] at 9:20 AM, he stated, "My mom is not getting the help that she needs. Like in the morning, she will call for assistance, and nobody will come not until like 45 minutes. A few times, she missed her doctor's [redacted] because she called for assistance so that she could shower, and they came after 45 minutes. I put complaints every two weeks, but still, they don't attend to her needs." A review of the facility's call light logs from [redacted] showed that Resident #87 called for assistance over 15 times with calls times ranging from 36 minutes to 1 hour and 36 minutes: [redacted] last over 52 minutes (mins.), [redacted] last over 1 hour (hr.) and 33 mins., [redacted] last over 36 mins., [redacted] last over 54 minutes, [redacted] last over 1 hr. and 28 mins., [redacted] last over 1 hr. and 36 mins.,	{A 079}		

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{A 079}	Continued From page 60 [redacted] last over 51 mins., [redacted] last over 55 mins., 07/272022 last over 37 mins., [redacted] last over 1 hour and 9 mins., [redacted] last over 47 mins., [redacted] last over 41 mins., [redacted] last over 1 hours and 39 mins., [redacted] last over 1 hr. and [redacted] last over 1 hr. and 26 mins. A review of Resident #87's health assessment dated [redacted] showed medical diagnoses and a history of Dyslipidemia, [redacted], and [redacted]. The resident needed supervision with toileting and assistance with ambulation, bathing, [redacted], eating, grooming, and transferring. On [redacted] at 1:24 PM, when asked about the delay in responding to resident's calls, Staff AE stated, "We weren't utilizing the alert systems properly. We have put in phone and gotten pagers." Uncorrected Class II	{A 079}		
{A 093} SS=I	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, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are	{A 093}		

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{A 093}	Continued From page 61 incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. 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 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	{A 093}		

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{A 093}	Continued From page 62 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 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	{A 093}		

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

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{A 093}	Continued From page 63	{A 093}		

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 Record Review and Interview, the facility failed to ensure the dietary needs were met for four (#104, #106, #109, #110) out of 108 sampled residents who had an indication of regular, special, , puree, and mechanical soft diets. The facility failed to accurately identify residents who required a diet.

Findings:

A record review on found a list posted in the kitchen with Resident #104's dietary needs listed the resident needing a puree diet, including no fish and no mashed potatoes. There was no physician order in his records for a puree diet for breakfast, lunch and dinner.

A review of Resident #104's Health Assessment completed on showed a diagnosis in , , , and Prostatic Hyperplasia and no known . Activities of daily living showed independent in eating, and supervision in ambulation and transferring but assistance in bathing, , self-care, and toileting. Resident #104 was listed as needing a

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 093}	Continued From page 64 regular diet. Interviewed on at 6:14 PM, the Dining Room Manager stated that she had a physician order for a puree diet for Resident #104, but she had to look for it. Interviewed on at 10:39 AM, the Dining Room Manager stated further that when Resident #104 first moved in, there was an order, and they have not received a revised order. The Dining Room Manager stated that she looked for his order and could not find the physician order for him (Resident #104). The Dining Room Manager stated, "I have not received any new orders." When asked about Kosher foods, the Dining Room Manager stated that they don't have much. A record review on of Resident #106's Health Assessment with a completion date of showed a diagnosis of , , , C- , surgery, , pre- , . Activities of daily living showed independence in toileting and transferring, but supervision needed in and self-care and assistance needed in ambulation, bathing, and eating. Special diet instructions: Type II low , Resident #106 was not listed on the list. A record review on of Resident #110's Health Assessment with a completion date of showed a diagnosis of ( ), , , , at Memorial Regional on . Resident diet showed , isocaloric, low (2 grams), low , kosher. A record review on of Resident #109's	{A 093}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 093}	Continued From page 65 health assessment showed a diagnosis of , , , and , . Resident was independent in activities of daily living and was prescribed a diet. Interviewed on at 2:45 PM, Resident #109 stated, "The food is still the same for me and my husband (Resident #110). I go shopping (grocery), and I can show my receipts." Resident #109 stated further that she wanted her Kosher foods. Interviewed on at 1:14 PM, Staff AE (Corporate Representative) acknowledged the issues. Uncorrected Class II	{A 093}		
{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	{A 162}		

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 _____	R 08/12/2022

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{A 162}	Continued From page 66 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. (f) A 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 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	{A 162}		

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 _____	R 08/12/2022

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{A 162}	Continued From page 67	{A 162}		

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 recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , 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 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 , , 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 , 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.,

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{A 162}	Continued From page 68 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 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 record review and interview, the facility failed to have a completed health assessment for 23 out of 118 sampled residents (Residents # 4, 6, 20, 21, 25, 27, 33, 43, 46, 49, 70, 73, 79, 80, 85, 87, 88, 91, 92, 100, 107, 110, 113). Findings included: Review of Resident #4's health assessment showed the special precautions section was left blank. Review of Resident #6's health assessment showed the special precautions and elopement risk sections were left blank. Review of Resident #20's health assessment showed the special precautions section was left	{A 162}		

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{A 162}	Continued From page 69 blank. Review of Resident #21's health assessment showed the special precautions and elopement risk sections were left blank. Review of Resident #25's health assessment showed the special precautions section was left blank. Review of Resident #27's health assessment showed the nursing/treatment/ , , service requirements section and elopement risk section were left blank. Review of Resident #33's health assessment showed the physical or sensory limitations and special precautions sections were left blank. Review of Resident #43's health assessment completed . . . . . showed that the nursing/treatment/ , , service requirements section was left blank. Review of Resident #46's health assessment completed showed the first page was left blank. Review of Resident #49's health assessment showed the date of the examination was left blank. Review of Resident #70's health assessment showed pages 1, 2 and 3 were left blank. Review of Resident #73's health assessment showed the medical history and diagnosis section were left blank. Review of Resident #79's health assessment	{A 162}		

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{A 162}	Continued From page 70 showed the type of assistance needed with medicationssection was left blank. Review of Resident #80's health assessment showed the special precautions section and date of the examination were left blank. Review of Resident #85's health assessment showed nursing/treatment/ , , , service requirements and the special precautions section were left blank. Review of Resident #87's health assessment showed the special precautions section was left blank. Review of Resident #88's health assessment completed showed the health care provider's credentials were missing. Review of Resident #91's health assessment completed showed the special precautions section was left blank. Review of Resident #92's health assessment completed showed the type of assistance needed with medications was left unchecked and the nursing/treatment/ , , service requirements and special precautions sections were left blank. Also, the section on the first page that should be completed by the facility was incomplete. Review of Resident #100's health assessment showed the physical or sensory limitations, the or behavioral status, the nursing/treatment/ , , , service requirements, the special precautions section were left blank. Review of Resident #107's health assessment	{A 162}		

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{A 162}	Continued From page 71 showed the special precautions section and the type of assistance needed with medications were left blank. Review of Resident #110's health assessment showed the medication list section, physician credentials, and date of the examination were left blank. Review of Resident #113's health assessment completed . . . . . showed the special precautions section was left blank. On at 5:05 PM, Staff AE acknowledge that the health assessments were incomplete. Class III	{A 162}		
{A 165} SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the	{A 165}		

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{A 165}	Continued From page 72 resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to	{A 165}		

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{A 165}	Continued From page 73 persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an adverse incident report with the Agency for Health Care Administration within one business day and fifteen days for four out of 119 sampled residents (Resident# 1, #2, #3, and #86).	{A 165}		

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{A 165}	Continued From page 74 Findings include: 1) A review of photographic evidence revealed two pictures of Resident #1 with a black , and a photo of the resident's left arm with reddish brown, circular marks that appeared to be . According to the date of the photo, the black was noted on . A review of the facility's internal incident reports showed no documentation of Resident #1's black . There was no documentation of an investigation into the incident. A review of the agency's adverse database showed that the incident regarding Resident #1 was not reported. 2) A review of the 24-hour communication report dated noted that Resident #2 had an incident on the prior ( ) where her were . The note stated that 'nobody reported the injury' on that Friday or did an incident report. A review of the facility's records showed no documentation of an internal incident report. There was no documentation of an investigation into the incident. A review of the agency's adverse database showed that the incident regarding Resident #2 was not reported. 3) A review of Resident #3's records revealed doctor notes dated stating, "Follow up at ALF for home health and skilled nursing for status post with wedge , and	{A 165}		

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{A 165}	Continued From page 75 A review of the agency's adverse incident database showed Resident #3's with injury was not reported. A review of the facility's incident report dated showed, "CNA (certified nursing assistant) noticed resident has on the left and right arms. CNA stated were not there yesterday during her shift." A review of the facility's records showed no documentation of an investigation into the incident. A review of the agency's adverse database showed that the incident regarding Resident #3 was not reported. 4) A review of Resident #86's record showed a prescription dated for an of the right , , and due to painful . Further review showed another prescription dated for a wheelchair due to a with the cage. A review of Resident #86's hospital records dated showed a 'History of Present Illness' that showed, "Patient sent from [facility] today after she . Was found on the ground this morning and does not know why she . She was seen here two days ago for similar and found to have a left which she complains still hurts." A review of the agency's adverse incident database showed Resident #86's and injury were not reported. During an interview on at 1:20 PM, when asked why the facility has yet to report any	{A 165}		

Agency for Health Care Administration

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{A 165}	Continued From page 76 of the incidents, the administrator stated, "It's a work in progress." Uncorrected Class III	{A 165}		