

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953688</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/15/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PALM BREEZE ALF</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1045 PALM AVENUE<br/>HIALEAH, FL 33010</b>                                   |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                      | Initial Comments<br><br>A biennial re-licensure survey, with a limited<br>mental health component, was conducted at<br>Palm Breeze ALF on . A deficiency was<br>identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A 000                                                                          |                                                                                                                          |  |                                                        |
| A 152<br>SS=E                                              | 59A-36.014(3) FAC Physical Plant - Safe Living<br>Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to<br>section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and,<br>3. Ensure that all existing architectural,<br>mechanical, electrical and structural systems,<br>and appurtenances are maintained in good<br>working order.<br>(b) Pursuant to section 429.27, F.S., residents<br>must be given the option of using their own<br>belongings as space permits. When the facility<br>supplies the furnishings, each resident bedroom<br>or sleeping area must have at least the following<br>furnishings:<br>1. A clean, comfortable bed with a mattress no<br>less than 36 inches wide and 72 inches long, with<br>the top surface of the mattress at a comfortable<br>to ensure easy access by the resident,<br>2. A closet or wardrobe space for hanging<br>clothes,<br>3. A dresser, or other furniture designed for<br>storage of clothing or personal effects,<br>4. A table or nightstand, bedside lamp or floor<br>lamp, and waste basket; and,<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate<br>keys to resident bedrooms to be used in the<br>event of an emergency.<br>(d) Residents who use portable bedside<br>commodes must be provided with privacy during | A 152                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| A 152                                                      | <p>Continued From page 1</p> <p>use.</p> <p>(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, and interview, the facility failed to ensure that all existing architectural, mechanical, electrical, structural systems, and appurtenances are maintained in good working order. The facility also failed to supply the required furnishing to each resident bedroom or sleeping area.</p> <p>Finding include:</p> <p>On . . . . . at 9:24 AM observed that resident's to 17 did not have either a bedside lamp or a floor lamp. Observed several rooms there were damages to the walls and doors and in . . . #., the window blinds were broken.</p> <p>In an interview with the Administrator on . . . . . at approximately 1:00 PM, the administrator stated that he would correct the problem.</p> <p>Class III</p> | A 152                                                                                  |                                                                                                                          |                          |                                                        |

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**PALM BREEZE ALF**

**1045 PALM AVENUE  
HIALEAH, FL 33010**

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