

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
---	--	--	--

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 Fourth Revisit to a Complaint Investigation (#2022005161 and #2022009263) was conducted at Plaza at Parksquare on 07, 2023 through 15, 2023. Deficiencies were identified at the time of the survey.	{A 000}		
{A 025} SS=E	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition _____ in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	{A 025}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025}	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a new health assessment from a health care practitioner for Residents #24 and #86 the residents had a change of condition that required updates on their health assessments. Findings included: A review of Resident #24's progress notes dated showed, "On , resident stated that she while walking toward her table. Resident complained of , in the ring . (Emergency Medical Services) was called. The resident was transported to [hospital]."	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025}	Continued From page 2 Review of Resident #24's hospital record dated _____ showed a 'History of Present Illness' stating "female who presents to the ED (emergency department) for _____. The patient tripped over something, causing her to _____ on her butt. She reports right fourth-_____. Pain is intermittent, worsened to touch and movement." A review of Resident #24's record showed she had an additional _____ on _____ at the facility. A health assessment dated _____ showed medical diagnoses and a history of _____, history of _____, and an _____. The resident was independent with ambulation and transferring and needed supervision with bathing, _____, eating, grooming, toileting and assistance with self-administration of medication. The health assessment indicated that the resident had no _____ precautions. A review of Resident #24's records showed no documentation of the resident being reassessed with a new health assessment by a health provider after her _____. Further review of Resident #24's record showed, she had an additional _____ on _____ at the facility. The resident had a health assessment dated _____ that showed a diagnosis and a history of _____, history of _____, and an _____. The resident was independent with ambulation and transferring and needed supervision with bathing, _____, eating, grooming, toileting and assistance with self-administration of medication. The health assessment indicated that the	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11696444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 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 025}	Continued From page 3 resident had no . . . precautions. The record had a . . . scale dated . . . with a score of 50 for . . . risks. Included, the record had a . . . care plan dated . . . with interventions for management. A review of the Morse . . . Scale showed that a score of 50 indicated a low risk for . . . and stated that standard . . . prevention interventions should be implemented. Further review of the resident record found no documentation of a new health assessment showing the resident had . . . precautions. A review of the facility's incident log revealed that Resident #86 . . . five times from . . . to . . . A review of Resident #86's Health Assessment form dated . . . showed a history and diagnoses of: . . . (. . .), Physical . . . and sensory limitations indicated the use of a walker and wheelchair for distance ambulation. . . . and/or behavioral status indicated Resident #86 was awake, alert, and oriented to person and place (AAOX2) with time was indicated, and no special precautions were noted. Activities of daily living status indicated Resident #86 needed assistance with ambulation, bathing, toileting, transferring and needed supervision with self-care. Resident #86 was independent for eating and needed assistance with self- administration of medications. The health assessment indicated that Resident #86 had no . . . precautions. A review of Resident #86's records showed no documentation that he was re-assessed after her . . . On . . . , at 8:50 AM, the Administrator stated, "We are updating all health assessments	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025}	Continued From page 4 if they need to, if they are not in the resident's records, there were probably misplaced." Uncorrected Class III	{A 025}			
{A 027} SS=E	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making _____ and remind residents about scheduled _____ for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a _____ health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assist with the arrangement of healthcare services for two out of 119 sampled residents (Resident#40 and Resident #104) after a change in condition. Findings included: 1) On _____ at 3:32 AM, observation showed Resident #40 sitting with Agency staff AAA attempting to reassure the crying resident. Further observation revealed Resident #40	{A 027}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
{A 027}	Continued From page 5 ... the hallway of the third floor (memory care unit) and crying with Agency staff AAA accompanying her at all times. During an interview on ... at 3:32 AM Staff AZ stated, "her ... is getting worst and the walking around and crying is routine. The family is refusing more medication therefore, an agency nurse monitors her throughout the night." During an interview on ... at 3:42 AM Staff AX stated "I assigned my staff [Agency staff AAA] to work with her 1 on 1 and sit with her 1 on 1 because the resident can't sleep and she is up with her at night." During an interview on ... at 4:54 AM, The Director of Resident Care stated "The ... was increased due to crying and ... The Psychiatrist increased the dose to target those symptoms. [Resident #40] ... the floor constantly. She has ... that's why she walks around. She is a ... risk therefore needs a staff for close supervision. Staff was instructed to stay closely not to stay in one room all night. [Resident #40] needs close supervision but not 1:1 care. This does not mean a change in her condition." A review of Resident #40's health assessment completed on ... revealed diagnoses of ... and ... The resident had physical limitations of ... and abnormal gait and was an elopement risk. The resident required supervision with ambulation, ... eating, grooming, and transferring and required assistance with bathing and self-administration of medication. Review of Resident #40's record revealed no	{A 027}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
---	--	--	--

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 027}	Continued From page 6 documentation of progress notes. Review of Resident #40's record revealed no documentation of a visit with the physician or an updated health assessment following the resident's change. 2) Observation on at 7:23 AM revealed a bag filled with laying on the floor near Resident #104's bed. On at 7:23 AM, observation showed Resident #104 sleeping with two half bed rails up on each side of the bed which formed a full bed rail. Further observation revealed a chair propped against the bed with the seat facing away from the resident in between the two half bed rails. Review of record revealed no documentation of a physician order for full bed rails. Further observation on at 7:23 AM revealed Resident #104's medications inside a cabinet in his room. Review of Resident #104's health assessment completed on revealed diagnoses of, retention, high, and a Further review revealed physical limitations of and nursing requirements of hospice. The resident had special precautions of being a risk and needed assistance with all activities of daily living and self-administration of medication. During an interview on at 7:23 AM Resident #104's private duty aide stated Resident #104 did not have a Medication Observation	{A 027}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
---	--	--	--

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 027}	Continued From page 7 Record (MOR) . She further stated that she recorded the resident's medications in a notebook. Observation on at 7:23 AM revealed a notebook with medication names handwritten with no dates, no scheduled times of dosage, and no initials indicating the medication had been given. Review of Resident #104's record revealed he was admitted to hospice care on Review of Resident #104's record revealed an integrated plan of care from hospice that stated, "The ALF [assisted living facility] will continue to assist patient with ADL's (activities of daily living) needs, simple treatments, and medication per regulatory standards." During an interview on at 8:00 am the Administrator stated that hospice was responsible for administering Resident #104's medication. When asked about the MOR that were not available, the Administrator stated that there wasn't any MOR for Resident #104. She was also notified that there were no hospice progress notes in his file. During an interview on at 12:12 PM the Hospice Team Manager stated "They always reconcile medication if there is any change in meds, if not we check every Wednesday in our team meetings with the doctor to see if there were any changes. Last Wednesday we reconciled the medicine. We are providing skilled nursing services, they do care. He recently had a They assess the tissue weekly. The ALF gives the daily medications." Review of Resident #104's hospice record	{A 027}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
---	--	--	--

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 027}	Continued From page 8 revealed he was receiving . . . care since . Review of Resident #2's record revealed no documentation that the resident was receiving care and no further documentation that the resident was receiving care from a healthcare provider. There was no documentation of a MOR. Class III	{A 027}		
{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	{A 058}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 058}	Continued From page 9 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 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:	{A 058}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
---	--	--	--

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 058}	Continued From page 10 Based on interview and record review, the facility failed to correct previous deficiencies regarding medication. The facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse to provide onsite quarterly consultation until the Agency for Health Care administration determines that such consultation services are no longer required. the facility also failed to provide documentation of consultant services regarding dietary services. Findings included: On during a fourth revisit to a complaint investigation, the facility had deficient practice regarding medication records and medication labeling and orders. On at 7:23 AM, Resident #104's friend stated that she gave the resident his medication after he had breakfast at about 10:00 AM. The friend further stated that there was not a medication observation record (MOR) for Resident #104 and that she wrote his medications in a notebook. Review of Resident #104's standard order of eleven medications revealed a discrepancy with the medications listed in the notebook due to the lack of documenting the administration assistance. On at 8:00 AM, the Administrator stated that hospice was responsible for administering Resident #104's medication and the facility did not have a MOR for the resident. The Administrator also stated when asked, that she did not have documentation onsite regarding the dietary consultant's recent visits. She stated that she would contact the dietician to obtain the	{A 058}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
---	--	--	--

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 058}	Continued From page 11 records. A review of the Agency for Health Care Administration records revealed that during a complaint investigation conducted from to , the facility was cited for deficient practices relating to assistance with self-administration of medication, medication administration, medication records, medication storage and disposal, and medication labeling and orders. During a revisit survey conducted from to , the facility had uncorrected deficiencies relating medication administration and medication records. During a third revisit survey conducted from to , the facility had deficient practice relating to medication storage and disposal. Uncorrected Class III	{A 058}		
{A 165} SS=F	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	{A 165}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 165}	Continued From page 12 incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the 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	{A 165}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 165}	Continued From page 13 Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to 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 submit an adverse incident report within 1 and 15 business days after the occurrence of a	{A 165}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 165}	Continued From page 14 adverse incident, through the agency's portal for Resident 55, who at her unit, suffered injuries and was transported to a local emergency unit. The facility also failed to report and neglect involving Residents #4, #20, and #87 to the Department of Children and Families (DCF). Findings Included: Review of Resident 55's record showed an health assessment dated The resident had a diagnosis of left, unspecified, unspecified, unspecified, unspecified The resident was alert and oriented,, forgetful at times, and had precautions. The resident needed assistance with all activities of daily living, except for being independent when eating, and assistance with medications. Notes on record showed that on at 12:40 PM, the resident was found sitting on the floor. She stated that she lost her balance and slid onto the floor while trying to sit on her chair; she denied The resident had no apparent injury, and refused emergency services. The resident will be checked every hour, and was encouraged to use her call pendant before getting up to go anywhere. On, the resident at her unit's kitchen, and found by a caregiver. The resident suffered injuries on her left and with to the left and right The resident was transferred to the nearest local emergency unit for further evaluation. Review of the facility's incidents reported showed the incident from was not reported. On at 9:45 AM, the Administrator	{A 165}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 165}	Continued From page 15 stated, "Not sure what happened, it was not reported, but we'll do it as soon as possible." On _____, the facility submitted the report to the agency. 2) A review of a family members complaint revealed that on _____, Resident #20 was placed in a _____ shower by Staff AB (caregiver) as a punishment for having soiled on himself. A review of the resident and facility records found no documentation of an investigation. There was no documentation that the facility reported the incident to DCF. A review of Staff AS (Caregiver) Disciplinary Action form dated _____ showed that she was given a verbal warning and education for yelling and leaving Resident #87 in her apartment naked for a long time. There was no documentation that the facility reported this incident to DCF. A review of Staff AS (Caregiver) Disciplinary Action form dated _____ showed that she left Resident #4 on the edge of her bed with her bra around her _____ while she (Staff AS) sat in the common area. There was no documentation that the facility reported this incident to DCF. Interviewed on _____ at 10:26 AM when asked who saw Resident #4 seated at the edge of the bed with her bra around her _____, the Assistant Director of Nursing stated, "I actually walked in and saw her with the bra around her _____. We counseled Staff AS." The Assistant Director of Nursing stated further that she did not make a call to DCF regarding Resident #4. On _____ at 8:50 AM, the Administrator	{A 165}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER PLAZA AT PARKSQUARE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 165}	Continued From page 16 stated, "No, two of them were not reported. We have notes for one when we contacted DCF." Uncorrected Class III	{A 165}			