

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>AL11910711</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/14/2023</b>                                                                   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MIDTOWN ASSISTED LIVING RESIDENCE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2001 POLK STREET<br/>HOLLYWOOD, FL 33020</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) |
| CZ830                                                                        | <p>408.821 FS Emergency Management Planning</p> <p>408.821 Emergency management planning; emergency operations; inactive license.-</p> <p>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:</p> <p>(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.</p> <p>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.</p> <p>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.</p> <p>(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.</p> <p>(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.</p> <p>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider</p> | CZ830                                                                                    |                                                                                                                          |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MIDTOWN ASSISTED LIVING RESIDENCE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2001 POLK STREET<br/>HOLLYWOOD, FL 33020</b> |                                                                                                                          |                                                        |
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| CZ830                                                                        | <p>Continued From page 1</p> <p>is located in a geographic area in which a state of emergency was declared by the Governor if the provider:</p> <ol style="list-style-type: none"> <li>1. Suffered damage to its operation during the state of emergency.</li> <li>2. Is currently licensed.</li> <li>3. Does not have a provisional license.</li> <li>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.</li> </ol> <p>(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.</p> <p>(4) . . . Licensees providing residential or inpatient services must utilize an online database</p> | CZ830                                                                                    |                                                                                                                          |                                                        |

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**MIDTOWN ASSISTED LIVING RESIDENCE**

**2001 POLK STREET  
HOLLYWOOD, FL 33020**

| (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 |
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| CZ830                    | <p>Continued From page 2</p> <p>approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) within a timely manner to ensure an annual review could be conducted by the local County Emergency Management Division as required.</p> <p>The findings included:</p> <p>On _____ at 11:56 AM, a review of a letter dated _____ from the Regional Emergency Services and Communications, County Emergency Management Division revealed that the facility's CEMP was approved through _____. The facility was required to submit their CEMP to the local county for approval no later than _____, allowing the county a 60-day window to approve the submission.</p> <p>On _____ at 12:00 PM, in an interview conducted with the Administrator, she stated she had submitted their CEMP to the county for approval. She was unable to produce any documented evidence at this time that she had submitted their plan. She stated she would send the proof via email.</p> <p>No email proof was forthcoming and as of the end of the survey date of _____ at 4:00 PM, the facility provided no evidence of any submission of their CEMP to the county for approval prior to or after the expiry date of _____.</p> | CZ830               |                                                                                                                          |                          |

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| CZ830                                                                        | Continued From page 3<br><br>Class III                                                                                       | CZ830                                                                                    |                                                                                                                          |  |                                                        |

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|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | <p>Initial Comments</p> <p>An unannounced Complaint (#2021011682, #2021011880, #2021012218, #2021013820, #2022002503, #2022011064, #2022016913, and #2022017035) and Generator Monitoring survey was conducted on _____ and _____ at Midtown Assisted Living Residence. The facility had a deficiency identified related to the Generator Monitoring at the time of the survey.</p> | A 000               |                                                                                                                          |                          |

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