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
	AL11911449	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA OF HALLANDALE BEACH	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

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A 000	Initial Comments A unannounced Relicensure, Extended Congregate Care (ECC), Complaints, (#2022010830, #2022017709, #2023003135, #2023000122, #2022006398, #2022018512, #2021001693, #2021005032, # 2021003173, #2021013593, #2022012124, #2023002127, #2023004418, #2023006211, #2023008360, #2021014044, #2020009953), and Generator Monitoring was conducted on throught [redacted] at Plaza of Hallandale Beach. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 025	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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.	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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, 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, observation and interview, the facility failed to provide care and services appropriate to 1 out of 3 sampled resident's records reviewed (Resident #7). As evidenced of the facility failure to provide supervision to Resident #7 to prevent the resident	A 025		

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A 025	Continued From page 2 for falling and/jumping out of the resident's room window, in which the resident substained injuries. The Findings Include: A review of the local Fire Rescue and (Emergency Medical Services) report dated documented they received a call on at 22:42:14 (10:42 PM), medic units were dispatched to facility location at 22:49:52 (10:49 PM) for primary impression noted as a attempt. Upon arrival, noted the male resident to be alert and oriented to self (AAOx1), laying on the ground on his left side below an open window that was approximately 15 ft above ground level. The patient( ) skin condition was due to the weather. It also documented the , was unable to answer questions other than to give his name. It further documented that the nursing staff stated that they went to the , 's room while doing their regular rounds and discovered that the , had or jumped from the second story. And that they did not know how long he had been outside on the ground, and that the , was alert when they found him and that his was unwitnessed. Patient transported as a level 1 alert to local hospital. Review of a medical report from a local hospital with a date of service of at 11:23 PM documented Resident #7 is a male with , X 2 (type 2) and who presented to the Emergency Room(ER) as a LVL 1 (Level 1) with a chief complaint of a from a second floor of an ALF. Resident #7 was diagnosed as sustaining acute IVH( ) to occipital horns and multiple .	A 025		

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A 025	Continued From page 3 . . . . . Further review of ER records documented resident as having COVID-19. Resident #7 was admitted on . . . . . to the hospital due to these injuries. Resident #7 was discharged from the hospital on . . . . . and transferred to a Rehabilitation (Rehab) facility. During review of Resident #7's facility records (nursing notes and witness statement) revealed documentation that on . . . . . at approximately 10:00 PM, Resident #7 exited the facility through his bedroom window located on the second floor in the Memory Care Unit (MCU). Observation of the Resident's room (#242) on . . . . . revealed the window Resident #7 exited from had two double screw window clamps, and a screw driven into the track in the window to secure it (photographic evidence obtained). Observation by this Surveyor could not be determined if they were there at the time of the incident. Observation also indicated the window had not been replaced since the incident, and the screen that was removed during the exit was bent at the bottom (photographic evidence obtained). A review of Resident #7's file revealed an admission date of . . . . . The Resident Health Assessment form - AHCA Form 1823 (AHCA 1823) dated . . . . . documented the Resident is a . male. Review further documents his diagnosis as . . . . . It also documented the . or heavioral status as . Nursing/Treatment/ . Services requirement noted as Home Health RN evaluate treat for administration, evaluate continued (. . . . .), ST (. . . . .) and (. . . . .). Special Precautions	A 025		

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A 025	Continued From page 4 noted as risk, and required constant supervision and an elopement risk. Activities of daily living (ADLs) for Resident #7 noted as needs assists with ambulation, and transferring; total with bathing, self-care (grooming) and tolieting. A review of the facility's Policy and Procedures Manual revealed an undated policy related to Care Giver Daily Schedule documenting rounds are to be conducted every two hours (photo evidence obtained). In an interview with Staff G (Direct Care Staff) on at 3:09 PM, she works the 3:00 PM - 11:00 PM shift, was working in the MCU the day of the incident and was the staff person who identified Resident #7 was missing. She stated she and Staff J put him to bed around 9:00 PM, and that was the last time he was seen prior to the incident. Staff G further stated in the interview that she was doing her rounds and went into Resident #7's room at approximately 10:00 PM on and did not see him. She stated that after looking throughout the MCU, she went into Resident #7s room and noticed the window was open. She stated she went to the window, looked down, and saw Resident #7 laying on the ground, and that he had jumped from the window. A review of the written statement by Staff G dated revealed her account of the incident but did not document Resident #7 had jumped from the window. A review of the Resident 's Evaluations dated , documented Resident #7 was not .	A 025		

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A 025	Continued From page 5 In an interview with Staff D (Direct Care Staff) on at 11:37 AM, she stated the Resident did not express any . . . . . thoughts. In an interview with Staff E (Direct Care Staff) on at 12:42 PM, she stated the Resident never said anything about . . . . . She stated Resident #7 did not ever say he wanted to commit . . . . . , and that she thinks he was just trying to leave the facility. In an interview with Staff E on at 12:46 PM, she stated Resident #7 required constant redirecting. She stated during her 7:00 AM - 3:00 PM shift, she had to repeatedly take a chair and sit by the door to keep him from going out. She stated they reported it many times to Management. A request was made to the Administrator for the facility's Incident Log on but was not provided during the Survey. In the interview with Staff G on . . . . . at 3:11 PM, she stated that she and Staff J were the only two staff working in the MCU the day of the incident. She further stated that she informed Staff B, who was working the 3:00 PM - 11:00 PM shift on the first floor, and he went to the location outside where Resident#7 landed and was found. On . . . . . a request was made to the Administrator for the facility's Incident reports, logs or the format they use. She stated she was not sure what the previous Administrator did with them but would look for them. The facility was unable to provide documentation demonstrating an investigation into how Resident #7 was able to jump out of of the window and obtained multiple injuries. Resulting in transporting to the local ER for further evaluation and care for these injuries.	A 025		

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A 025	Continued From page 6 A review of the written statement dated [redacted] by the Staff B (Med-Tech) documented he was called to the MCU by Staff G, who was not able to find Resident#7 at 10:15 PM and he rushed to the side of the building where his window was located and found the Resident lying on his side and complaining of [redacted]. It documented 911 was called and the Resident was transported to a local hospital. In an interview with Staff J (LPN Supervisor) on [redacted] at 3:56 PM, she stated the resident was normal that day, he was strong and broke all his furniture. She stated that Resident#7 was [redacted] and would walk holding the wall. She stated she was here the night of the incident and helped put him to bed around 9:00 PM. She stated he never said anything about jumping, leaving, or wanting to take his life. A review of the Staff Schedule revealed that there were 2 staff (Staff G and J) working the 3:00 PM - 11:00 PM shift when the incident occurred. It also revealed that there are only two (2) Staff working in the MCU during the shift, and two care staff (along with a Nurse) in the AL during the 3:00 PM - 11:00 PM shift. On [redacted] at 12:41 PM this Survey conducted an additional tour of the MCU and observed there were only staff attending the 24 Residents. As Resident #7's AHCA form 1823 dated [redacted] documented he required constant supervision, a request was made to the Administrator in an interview on [redacted] at 3:44 PM, for the logs documenting the dates/times Resident #7 was observed, supervised, or attended to by staff. No	A 025		

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A 025	Continued From page 7 documentation was provided during the Survey. Specifically, documentation relating to the provision of constant supervision for Resident #7 as documented in his AHCA 1823 form. Class III	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . Hotline,	A 030		

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A 030	Continued From page 8 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 9 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		

A 030 Continued From page 10 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

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A 030	Continued From page 11	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 12 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 record review and interview the facility failed to establish and maintain a current written grievance procedure for responding to and receiving resident complaints with documented resolution. The facility also failed to ensure residents resided in a safe living environment.	A 030		

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A 030	Continued From page 13 The finding included: a) During an interview conducted with the Administrator at 10:34 AM, a request was made for the facility Grievance Policy and Procedure. Review of the facility policy titled, Resident's Rules and Regulations (undated) revealed the following. 1. Resident must be present at food serving time. Serving times: 14 hours between dinner and breakfast the next morning; 2 to 6 hours between meals. Snacks are offered, however are not considered meals. Breakfast: between 7:30 AM to 9 AM; Lunch 12 noon to 1:30 PM 2. Residents have the right to make [illegible] and be seen by third-party providers will be required to sign facility sign in logbook. 3. Anything broke by the resident will be charged to the residents account after termination of residents residency. 4. If the TV or radio is on, volume should be low, and do not disturb others. 5. Violence, fighting, [illegible] behavior or language towards another resident, staff or guest will not be tolerated. 6. Residents are to treat staff, guest and other residents with consideration and respect. 7. Absolutely no smoking in the facility. Smoking is only permitted in the smoking patio of the facility. 8. Resident must sign out when departing from the facility for a weekend, vacation with family or friends and/or when leaving to unknown/ unscheduled whereabouts. Resident must sign [illegible] in upon return. 9. Residents are not allowed to have guest stay in their quarters. 10. Residents are encouraged to inform the staff of their conflicts immediately. Residents grievances will be conducted at monthly Resident Council Meetings, unless needing immediate attention. On at 10:34 AM, during an interview conducted with the Administrator, she stated she	A 030		

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A 030	Continued From page 14 had been in the position for less than a month, then provided a Grievance Log from 2019 with old complaints. The Administrator was unable to provide current resident complaints of activities, roaches and water temperature. b) Review of a Department of Health (DOH) Inspection Report dated . . . . . documented observation of the presence of . . roaches in the kitchen and no effective control measures or methods implemented such as no routine inspection of incoming shipments of food and supplies; no routine inspection of the premises for evidence of pests/ trapping; using approved pesticides/eliminating harborage conditions; controlling entry through exterior openings using screens, air curtains or other measures. The Inspection Report documented an Unsatisfactory finding (Copy obtained). In an interview conducted with the DOH representative on . . . . . at 11:07 AM, he stated he made observation of live and . . roaches in the kitchen. In addition, he stated the hot water took far too long to reach a satisfactory temperature of 105 degrees in the kitchen. In an interview conducted with the Dietary Manager on at 11:56 AM, she informed the surveyor that the hot water had not been working since the previous weekend (. . . . . - . . . . .). During observation by the surveyor on . . of the facility's common/TV area located in the southwest section of the first floor, observation was made of live roaches crawling across the floor (Video evidence obtained).	A 030		

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A 030	Continued From page 15 During an observation of the Memory Care Unit (MCU) located on the second floor of the facility [redacted], this surveyor observed live and [redacted] roaches at the baseboard located on the northeast wall of the Dining/Activity room (Photographic evidence obtained). Observation was made of chairs in the MCU's dining room located in the second floor of the facility, revealed moldy-like substance on the wooden [redacted], and ripped plastic and grimy substances on the seating section of chairs (Photographic evidence obtained). Observation of the front door of the facility by this surveyor on [redacted], revealed double-glass doors with an exit bar that allows for exiting the facility. Observation was made of the alarm system on the door had the wires for the contact cut as the system does not work. Observation by this surveyor of the lock on the outside of the door that is used to lock the door and prevent entrance into the facility, does not lock, thus entry into the facility by anyone could take place 24 hours a day. This surveyor observed a sign on the front entry doors stating the door is locked at 7:00 PM. This surveyor requested a demonstration of how the door is locked to prevent unofficial entry. During a demonstration by the Maintenance Director on /20203, the locking apparatus turned completely around numerous times and failed to lock the door, prompting the Maintenance Director to respond that it does not lock. In an interview conducted with the Administrator on [redacted] at 12:41 PM, she was informed of the observation made of the front entry door that was unable to lock, always allowing for unabated entrance by anyone. She stated the door	A 030		

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A 030	Continued From page 16 repairman was coming to check and hopefully repair it. In an interview conducted with the Maintenance Director and Representative from the door repair company on at 3:11 PM, the repair technician stated the locking apparatus appeared to be controlled by a maglock that was controlled by the buzzer at the front desk. This surveyor observed the technician examining/attempting to lock the door but was unable to secure it. Class III	A 030		
A 032	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	A 032		

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A 032	Continued From page 17 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 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.	A 032		

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A 032	Continued From page 18 This Statute or Rule is not met as evidenced by: Based on interview the facility failed to conduct/or document at least two elopement drills per year and ensure that all direct care staff participated in the drills as required. The findings included: In an interview conducted with the Administrator on [redacted] at 10:24 AM, a request was made for the facility's Elopement Drills for the past two years. The documentation was not provided at that time. In an interview conducted with the Administrator on [redacted] at 2:23 PM, a second request was made for the facility's Elopement Drills. The documentation was not provided at that time. In an interview conducted with the Administrator on [redacted] at 3:47 PM, a third request was made for the facility's Elopement Drills. She stated she was unsure where the previous Administrator may have placed them, and no documents were provided at that time. In an interview conducted with the Administrator on [redacted] at 10: 43 AM, a fourth request was made for the facility's Elopement Drills. No documentation was provided during the survey. Class III	A 032		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep	A 054		

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A 054	Continued From page 19 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 _ 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 , 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 observation, record review and interview, it was determined that the facility failed to ensure the electronic Medication Observation Record (eMOR) was completed for 1 out of 6 sampled residents observed during medication pass observation, specifically Resident #27, who required assistance with the self-administration of medication.	A 054		

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A 054	Continued From page 20 The findings included: A review of Resident #27's facility record revealed the resident was admitted on with a medical history and diagnosis of the following: with , left side ; physical and sensory limitations with left sided ; and was wheelchair bound. On at 10:25 AM, during observation of assistance with the self-administration of medication, there was no evidence that the resident received the following medications identified as follows: a. 500 milligrams (MG) take 1 tab by twice daily 9:00 AM and 5:00 PM doses from through were not given. b. , 100 MG take 1 capsule by twice daily 9:00 AM and 9:00 PM doses from through were not given. c. , 5 MG take 1 tablet by twice daily 9:00 AM and 5:00 PM doses from through were not given. d. 12.5 MG take 1 tablet by twice daily 9:00 AM and 5:00 PM doses from through were not given. e. 10 MG take 1 tablet by twice daily 9:00 AM and 5:00 PM doses from through were not given. f. 25 MG take 1 tablet by once daily 9:00 AM and 5:00 PM doses from through were not given. In an interview conducted with Certified Nursing Assistant Staff H about the process when a resident is admitted to the facility, she stated that when a resident is admitted to the facility, the facility is to fax the medication list, insurance	A 054		

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A 054	Continued From page 21 information, Facesheet and any prescriptions to the pharmacy. She further stated the pharmacy would send the medication and or just enter the resident under profile only because the resident does not need any medication. In an interview with conducted with Medication Technician Staff I at 10:35 AM about the process for notifying the pharmacy about residents who are admitted with their own medication, revealed that the Supervisor on duty is to fax the admission/discharge profile of the resident along the resident insurance, social security card, and the Resident Health Assessment 1823 form, sheet, medication list or physician orders that the resident comes with on admission to the facility and if the resident is admitted to the facility with medications. She further stated when the paperwork is sent to the pharmacy, the pharmacy is advised to profile only the resident, that way no medication is sent for the resident due to the resident having their own medication. The eMOR will only show the resident's list of medications so the pharmacy does not send medications and double bill the insurance, and then when the resident has exhausted all medication that they came to the facility with staff or the Nursing Supervisor will then call the pharmacy and make them aware that the resident can be taken off of profile only. At that point the pharmacy can start sending the resident's medications and billing can start with the insurance company for the resident. Further interview with the Nursing Supervisor revealed that once the profile has been created by the pharmacy, the facility will be able to approve all the medication, and the Medication Technician or the Nurse would be able to administer the medications and sign the eMOR as ordered by the Physician.	A 054		

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A 054	Continued From page 22 The Administrator was notified of these findings during the exit interview conducted on [redacted] at 3:24 PM. The Administrator acknowledged the findings and provided no additional documentation for review at this time. (Photographic evidence obtained.) Class III	A 054		
A 077	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 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	A 077		

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A 077	Continued From page 23 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. 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 [illegible] 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	A 077		

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A 077	Continued From page 24 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 , . , 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	A 077		

Agency for Health Care Administration

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A 077	Continued From page 25 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 observation and record review the facility failed to ensure the timely report, remove/or add an Administrator to accurately reflect the Administration of the facility. The Findings Include: During review of the Florida Healthfinder (Facility/Provider Locator) website on , observation was made of the facility's Administrator of record. The review revealed the previous Administrator was still listed as the Administrator. In an interview conducted with the current Administrator on at 10:37 AM, she stated she was hired as the new Administrator about 3 weeks ago. A review of the Administrator confirmation of hire letter dated document she was hired effective , 14 days prior to the Survey. In an interview conducted with the Administrator on at 11:05 AM, she stated that the previous Administrator's employment at the facility ended on . A review of Florida Health Finder revealed the previous Administrator was still listed as the Administrator at the time of survey.	A 077		

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A 077	Continued From page 26 Class III	A 077		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice	A 081		

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PLAZA OF HALLANDALE BEACH	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

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A 081	Continued From page 27	A 081		

orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible] may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who

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A 081	Continued From page 28 have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 081		

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A 081	Continued From page 29 failed to have documented evidence that 4 out of 4 staff, the Administrator, Staff A, Staff B, and C, had evidence of the required mandatory staff in-service training. The findings included: The review of the personnel file for the Administrator revealed a date of hire of to work the 9:00 AM to 5:00 PM shift. Further review revealed the Administrator was not CORE trained and staff training for 2-hour Preservice Orientation was not available for review. During the review of the personnel file for Certified Nursing Assistant (CNA) Staff A revealed a date of hire of to work the 7:00 AM to 2:00 PM shift. Further review of the personnel file for CNA Staff A revealed no certificate of a 2-hour Preservice Orientation, Elopement Response Training and Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, and Incident Reporting Training available for review. During the review of the personnel file for Licensed Practical Nurse (LPN) Staff B revealed a date of hire of to work the 3:00 PM to 11:00 PM shift. Further review of the personnel file for LPN Staff B revealed no certificate of a 2-hour Preservice Orientation, and Elopement Response Training available for review. During the review of the personnel file for Home Health Aide (HHA) Staff C revealed a date of hire of to work the 11:00 PM to 7:00 AM shift. Further review of the personnel file for HHA Staff C revealed no training on Reporting Major Incidents, Reporting Adverse Incidents, Facility	A 081		

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A 081	Continued From page 30 Emergency Procedures, and Incident Reporting Training available for review. Preservice Orientation includes training in Residents' Rights and ALF (Assisted Living Facility) services with a certificate requiring signatures by both the Administrator and the employee prior to interacting with residents. On , the surveyors met with the Administrator to discuss the findings of the survey. She was informed of the missing staff in-service trainings. She acknowledged the findings. Class III	A 081		
A 086	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , , and , , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this	A 086		

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A 086	Continued From page 31 requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of	A 086		

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A 086	Continued From page 32 Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related .	A 086		

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A 086	Continued From page 33 (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 4 direct care staff had the required and Related (ADRD) Level I Training (Staff D) and/or the annual 4 hours of Level II ADRD continuing education required, (Staff B and Staff D). The findings included: A review of the facility's website on revealed that it advertises the admission of residents with and Related thus requiring direct staff to have the training. Further, the facility has a locked secure Memory Care Unit. On a review of the facility's employee files was performed. A review revealed that 3 of the 4 staff files presented for review did not contain evidence of the training. A review of the facility file for Certified Nursing Assistant Staff B who was hired on 11/03/2021 and provides direct care to residents, revealed it did not contain evidence that she had received the required 4 hours of Level II ADRD training within 9 months of hire or in 2023 thus far. A review of Home Health Aide Staff D's facility file revealed she was hired on and	A 086		

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A 086	Continued From page 34 provides direct care for residents. Further review revealed it did not contain evidence that she had received the required 4 hours of Level 1 ADRD training required within 3 months of hire, nor the 4 hours of Level 2 ADRD training required within 9 months of hire or in 2023 thus far. During an interview conducted with the Administrator, this surveyor advised her that the documents were not in the file and she was provided an opportunity to review the files. No additional information was provided, and she acknowledged the findings. Class III	A 086		
A 093	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, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. 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	A 093		

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A 093	Continued From page 35 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 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	A 093		

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A 093	Continued From page 36 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 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	A 093		

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A 093	Continued From page 37 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 observations, record review and interview, the facility failed to follow a therapeutic diet as ordered by a Health Care Provider 1 of 18 sampled residents (Resident #16) . The findings included: On . . . . . at 12:10 PM, Resident # 16 was observed during lunch sitting at the dining table having lunch, consisting of rice, green peas, and whole fish. During an attempted interview with the resident to inquire if the resident had any concerns with the food being provided for taste and appearance, the resident just stared and tried to answer the surveyor but was unable to respond. The surveyor immediately went to the nursing station to get the attention of the Nursing Supervisor. The surveyor told the Nursing Supervisor that during an attempted interview with Resident #16, he sat at the table attempting to answer the surveyor with staring , , and unable to speak. The Nursing Supervisor immediately went to check on the resident but found the resident in stable condition. At 12:15 PM on . . . . . , the surveyor asked Medication Technician Staff I for Resident #16's facility records. The Nursing Supervisor at 12:17 PM, provided Resident #16's records. Upon review of the resident's record, it revealed the resident was to consume a mechanical soft diet with thin liquids dated . . . . . , however the resident was observed to have been consuming a regular diet. Further review of the resident's record revealed the Resident Health Assessment	A 093		

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A 093	Continued From page 38 AHCA 1823 form dated . . . . . , documented a medical history and diagnosis of Late effects of . . . . . , Aphasia (difficulty speaking), high . . . . . , and . . . . . . Further review of the record revealed a diet change to mechanical soft with thin liquids, dated . . In an interview conducted on at 12:20 PM with the Nursing Supervisor, she acknowledged that Resident #16 was to have a mechanical soft diet, further stating there is a binder for all residents that have a therapeutic diet at the nursing station and in the kitchen. She provided the binders to the surveyor, and she further stated that the facilities' kitchen and the nursing station also has a binder with all residents that are on a therapeutic diet. She further stated she is the only Nursing Supervisor in the building to supervise the entire building during the hours of 7:00 AM through 3:00 PM. A review of the therapeutic binders for the kitchen and nursing station revealed the facility has a total of 18 residents that are on a therapeutic diet, to include Resident #16, at the time of the survey. (Photographic evidence was obtained.) Class III	A 093		