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
	AL11910963	A. BUILDING: _____ B. WING _____	R 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to a generator monitoring survey was conducted at Hazel Cypen Tower on . Deficiencies were identified at the time of the survey.	{A 000}		
{A 055} SS=E	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require	{A 055}		

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{A 055}	Continued From page 1	{A 055}		

central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and,
4. Kept separately from the medications of other residents and properly closed or sealed.
(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.
(e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are

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{A 055}	Continued From page 2 still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure over the medications are kept locked and secured for 1 out of 142 residents. Findings included: Observation on at 10:56 AM, showed unlocked Skin Protectant on top of nightstand in # . Photographic evidence was captured. Interviewed on at 01:51 PM, the Nursing Consultant stated, "we have been going around the rooms daily to make sure there are no unlocked medications." Interviewed on at 2:00 PM, the Administrator stated, "we have the nursing consultant doing rounds, and we do rounds weekly to make sure there are no unlocked medication." Class III.	{A 055}		

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{A 058} SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or	{A 058}		

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{A 058}	Continued From page 4 registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility is required to employ the consultant services or a licensed registered nurse or pharmacist who will provide onsite quarterly consultations until it is determined that such consultation services are no longer required. The facility received a Class III uncorrected deficiency of Medication- Storage and Disposal. Findings included: Observation on at 10:56 AM, showed unlocked Skin Protectant on	{A 058}		

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{A 058}	Continued From page 5 top of nightstand in # . Photographic evidence was captured. Interviewed on at 01:51 PM, the Nursing Consultant stated, "we have been going around the rooms daily to make sure there are no unlocked medications." Interviewed on . at 2:00 PM, the Administrator stated, "we have the nursing consultant doing rounds, and we do rounds weekly to make sure there are no unlocked medication." Class III	{A 058}		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging	{A 152}		

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{A 152}	Continued From page 6 clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment, free of hazards to the residents. The facility also failed to maintain electrical systems locked and maintain existing facilities in good order. Findings Included: Observation on at 7:13am showed that on the second floor in the hallway on the of the elevator shaft, there was electrical fuse conduit box. One of the electrical boxes were unlocked and could be opened. There was an electrical timer device with exposed 220 volt wiring. There was a label written in sharpy that stated that the timer devices was for the pool outside. (photographic evidence obtained) Observation on at 7:20am showed engineering staff was observed on the second floor removing the locking mechanism from the	{A 152}		

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{A 152}	Continued From page 7 doors. Observation on at 7:32am showed that on the second floor gathering area there was missing floor molding and chipped paint. (photographic evidence obtained) . Interview on at 7:34am with the Administrator showed that he acknowledged the wear and tear on the memory floor and that the moldings and paint will be fixed. Class III	{A 152}		
{A 182} SS=F	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observations, interviews, and reviews of records, the facility failed to ensure that the staff are trained in their duties and responsibilities in implementing the emergency management plan for two out of 11 (Staff B & K) sampled staff. The staff did not know where and how the residents would be evacuated in case of an emergency. The staff could not provide an accurate census of residents and could not ensure how all residents were accounted for	{A 182}		

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{A 182}	Continued From page 8 during an emergency. Findings included: Observation on at 6:05 AM showed that the facility was a six-story structure. During an interviewon at 6:07 AM, Staff K stated that there were about 100 residents in the building but could not confirm the exact number. An interview on at 6:07 AM with Staff K showed that she was unfamiliar with the emergency management plan and could not convey how or where residents would be evacuated. She identified two alternative exits on the first floor, one leading into the pool area. However, she acknowledged that the one leading to the pool area would not be a safe area to evacuate residents to, when asked if this was safe. She was unfamiliar with the use of the elevator during emergencies and/or devices to bring down residents using the stairs. An Interview on at 6:18 AM with the custodial staff showed that he was unfamiliar with the emergency management plan. He stated that he does not interact with resident other than for custodial reasons but would help in an emergency, even if he had "to carry resident out on his ." During an interview on at 6:45 AM Staff B stated that there were 92 residents in the building and then changed her count and said there were 98. An interview on at 6:45 AM with Staff B showed that she was unfamiliar with the	{A 182}		

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{A 182}	Continued From page 9 emergency management plan and could not convey how or where residents would be evacuated to and the staff responsibilities during an emergency. She stated that she would coordinate staff responsibilities during an emergency. She further stated that she would call for "backup," but did not elaborate who the backup was. She stated that she would move residents to areas away from windows and suggested residents could be moved to upper floors if needed. She was also unfamiliar with the use of the elevator during emergencies and/or devices to bring down residents using the stairs. During an interview on 6:47 AM the Administrator stated that the census was 96 residents and that there might be 'some in rehab'. When asked why everyone had a different census count, he did not answer. During an interview on 6:47 AM the Administrator stated that the facility had monthly drills and hired a consultant, when asked about the facility emergency plan. He further stated that the employees also took an "online course." According to the Administrator, resident could be moved to other mutual aid facilities in and outside the . , including another facility belonging to the parent cooperation. He stated that the elevators worked during an outage or emergency because they were connected to the generator, and that the facility had a stair wheelchair as well. In an interview on 6:47 AM the Administrator, when asked why employees' responses were not consistent with the plan he described, shook his and said, "everyone should know." Review of census printout dated	{A 182}		

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{A 182}	Continued From page 10 show 97 residents living in the facility. Class III	{A 182}		