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
	AL11969444	A. BUILDING: _____ B. WING _____	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A standard re-licensure survey was conducted at Plaza At Parksquare from through . The provider had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 observation, record review and interview, the facility failed to maintain 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 for two (Residents #2, and 3) out of 39 sample residents. Findings: 1) Observation on at 8:26 AM found Resident #2 in # .	A 025		

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A 025	Continued From page 2 A review of the adverse incident database showed Resident #2's room was burglarized including theft of his credit cards, jewelry and cash on . A review of Resident #2's progress notes showed no documentation on , including a police case number of the incident. Interviewed on at 12:49 PM the Administrator stated that he thought the information was not supposed to go there. 2) Interviewed on at 11:01 AM the DON stated that Resident #5's levels dropped to 55 mg/dL. The DON stated further that her levels dropped, and she had to get a new prescription. However, there was no new prescription for administration. A review of Resident #5's health assessment with a completion date of showed a diagnosis of 's , , History of , , , , A review of Resident #5's progress notes showed no documentation of levels dropping. The Center for Control and Prevention states: "A below 70 mg/dL is considered low. Low , also known as , can be very dangerous. It's important to know what to do so you can treat ."	A 025		

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A 025	Continued From page 3 Interviewed on at 12;49 PM the Administrator acknowledged that there was an issue. Class III	A 025		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition	A 031		

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A 031	Continued From page 4 and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Resident #5 had an updated recertification plan for Administration and a	A 031		

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A 031	Continued From page 5 daily ᵕ / log provided by home health services. The facility failed to ensure Resident 5 had a prescription for administration on file. The facility failed to document communications about Resident #5's condition and response to treatment or services ordered by the physician. Findings: Interviewed on at 11:00 AM when asked for the recertification plan and the prescription for administration, a daily ᵕ / log for Resident #5, the Director of Nursing (DON) stated that she had to look for it. However, the DON called the doctor's office to get the prescription. A review of Resident #5's health assessment with a completion date of showed a diagnosis of 's , , , History of , , . Interviewed on at 11:01 AM the DON stated that Resident #5's ᵕ levels dropped to 55 mg/dL. The DON stated further that her ᵕ levels dropped, and she had to get a new prescription. However, there was no new prescription for administration. A review of Resident #5's progress notes showed no documentation of ᵕ levels dropping. Interviewed on at 12:49 PM the DON stated that the information was in the medication observation record. Interviewed on at 12:49 PM, the	A 031		

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A 031	Continued From page 6 Administrator acknowledged that the documents were not onsite. The Center for Control and Prevention states: "A below 70 mg/dL is considered low. Low , also known as , can be very dangerous. It's important to know what to do so you can treat ." Class III	A 031		
A 032 SS=D	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 risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained	A 032		

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A 032	Continued From page 7 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to make at a minimum	A 032		

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A 032	Continued From page 8 a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address and telephone number. Findings: A review of the elopement risk list showed the following residents to be at risk: #22, 23, 24, 25, 26, 2, and 28. Observation on at 12:36 PM after Staff F (Nursing Supervisor) rolled up both sleeves on Resident #26's arm found no or tracking device. Observation on at 8:59 AM found Staff J (Medication Technician) on the Memory Care Floor. Interviewed on at 8:59 AM when asked about residents at risk for elopement, Staff J stated residents have a tracking watch. Interviewed on at 12:49 PM when asked what the elopement policy for elopement risk was, the Administrator stated, "Residents at risk for elopement will have a on their person and in addition to that, will wear a tracking device." The Administrator stated further that Resident #26 takes off her tracker. The Administrator concluded, "We will keep checking." Interviewed on at 12;49 PM the Director of Nursing stated that she identified some residents as elopement risk, but it does not mean that they will elope. The facility elopement policy states: "In the event	A 032		

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A 032	Continued From page 9 that a resident, at admission is determined to be at risk for elopement by facility staff, this information will be documented in the resident's record. In addition, the resident will have the following: At a minimum, a daily effort to determine that at risk residents have identification on their persons that include their name, the facility name, address and telephone number." Class III	A 032		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's	A 036		

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A 036	Continued From page 10 recommendations. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to reduce the risk of transmission of for one (Resident #21) out of 39 sampled residents. Findings Included: Observation on at 8:26 am showed Staff G (Medication Technician) entered the elevator and pressed the button for the sixth floor. Upon further observation, it was noted that she accessed the computer to retrieve the resident's medication observation records (MOR). Staff G then collected Residents 21's medication packs. After that, she poured a cup of water and took an empty cup. Before entering the resident's room, Staff G knocked and held the doorknob. Observation on at 8:27 am showed Staff G popped several medications from a pack into an empty clear cup and gave it to Resident #21. Further Observation showed that Staff G did not perform any hygiene. She did not wash her or use sanitizer before, during, or after assisting Resident #21 with medication administration. Interviewed on at 8:35 am Staff G stated she received training in control policies. A review of Staff G employee records showed a hire date of . Staff G had Control training on . During the exit interview on at 12:50 pm the Administrator acknowledged that the staff	A 036		

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A 036	Continued From page 11 did not implement control during the medication administration. Class III	A 036		
A 055 SS=D	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 12 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	A 055		

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A 055	Continued From page 13 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, interview, and record review the facility failed to ensure all medications were kept in a locked cabinet, locked cart, or other locked storage receptacle room, or area always. Findings Included: Observation on at 8:27 am showed during tour Resident #21 had over the counter medication Safe ⌄ and ⌄ on the nightstand. A review of Resident 21's health assessment dated showed the resident needed assistance with self- administration of medication. During the exit interview on at 12:50 pm the Administrator acknowledged that there was over the counter medication inside of the resident room. Class III	A 055		

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A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their	A 078		

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A 078	Continued From page 15 qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff J (Medication Technician), Staff L (Certified Nursing Assistant) and Staff M (Certified Nursing Assistant) were able to demonstrate and the techniques consistent with their level of education, training, preparation, and experience. Staff J, L, and M failed to and demonstrate the appropriate technique when performing ( ) on a victim. The Administrator failed to obtain a valid card.	A 078		

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A 078	Continued From page 16 Findings: 1) Observation on at 8:59 AM found Staff J working on the Memory Care floor. Interviewed on at 8:59 AM Staff J stated that she worked from 6:00 AM-2:30 PM. When asked what she would do if she found a person unresponsive, Staff J stated that she would call the [nursing supervisor]. Staff J stated further, "I would do three , . I am not sure about breath." When asked if she took , Staff J stated that she did. When asked if it was done in person, Staff J stated, No. it was online." A review of Staff J personnel records showed a hire date of with no valid card on file. 2) Interviewed on at 6:34 AM Staff L stated that she worked from 10:00 PM-6:30 AM. When asked what she would check to see if a person needs , how she would know a person needs , Staff L stated, "I think it was 40 , , and I don't know the breaths. I don't remember." A review of Staff L personnel records showed a hire date of with no valid card on file. 3) Interviewed on at 3:31 PM Staff M stated that she worked from 2:00 PM-10:30 PM. When asked about when she would do ,	A 078		

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A 078	Continued From page 17 Staff M stated that if a person was . Staff M stated that she would call their name. Staff M stated that she can't remember how many , . Staff M stated further, "I don't remember. I forgot." A review of Staff M's personnel records showed a hire date of and a valid card dated . 4) A review of the Administrator's personnel records found no valid card on file. Interviewed on at 7:04 AM when asked if he had a valid card, the Administrator stated that his card was expired. Interviewed on at 12:49 PM the Administrator acknowledged that the employees did not know the techniques. According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths." Class III	A 078		
A 093 SS=D	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	A 093		

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A 093	Continued From page 18 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 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	A 093		

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A 093	Continued From page 19 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 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.	A 093		

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A 093	Continued From page 20 (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 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 observation, record review, and interviews, the facility failed to ensure two residents (#6 and 36) out of 39 sampled, without access to the kitchen were offered at least one snack per day. Findings: Interviewed on at 9:10 AM Resident #6 stated that she was a vegetarian and normally the facility had bananas. Resident #6 stated further that it has not been any lately. Interviewed on at 9:15 AM Resident #36 stated that they run out of bananas every week. Observation at 9:25 AM found only five bananas in a box which appeared to be overripen. Photographic evidence obtained.	A 093		

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A 093	Continued From page 21 Interviewed on at 9:23 AM when informed that the residents were complaining about no bananas, the Food Service Director stated that he had a shipment coming in. The Food Service Director stated further that he only orders so much because they go bad too fast. However, the Food Service Director provided an invoice dated for bananas ordered. Interviewed on at 10:39 AM acknowledged that there were no bananas. The Cleveland Clinic states: "Vegetarian diets continue to increase in popularity. Reason for following a vegetarian diet vary but the health benefits. Following a vegetarian diet may reduce the risk of , and some . To get most out of a vegetarian diet, choose a variety of health plant-based foods. It's easy to see why some call bananas "nature's perfect snack." It contains: 105 calories, 1 gram of protein (making it a high protein fruit), 28 grams of , 15 grams of sugar (natural) three grams of , 422 milligrams of , 10 milligrams of C, 0.43 MG of B6, and 32 milligrams of ." Class III	A 093		
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,	A 152		

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A 152	Continued From page 22 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 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 ensure all that existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. Findings Included:	A 152		

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A 152	Continued From page 23 Observation on at 8:40 am showed during tour in the smoke detector was missing, and wires were exposed. Interviewed on at 8:47 am the Administrator stated, "the Private Duty Aide ended up removing it because it was making a beeping sound." Observation on at 7:39 am showed during tour on the 7th floor, the door handle was missing that had access to the employee elevator. (corrected while on site) Observation on at 9:42 am showed during tour on the 4th floor, the door glass was found to be cracked upon entering the common area. Interviewed on at 9:43 am the Administrator stated, "I'm getting an estimate." Class III	A 152		
A 190 SS=E	59A-36.023( ) & (3)(b); 429.14( ) Administrative Enforcement 59A-36.023( ) & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial	A 190		

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A 190	Continued From page 24 standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 58A-5.0181, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 58A-5.021, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 58A-5.0182,	A 190		

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A 190	Continued From page 25 F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 58A-5.0182, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for , , and transportation to , , ; 5. Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 58A-5.019, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 58A-5.020, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 58A-5.029, F.A.C., relating to mental health residents' community support living plan; 9. Section 429.07, F.S., and Rule 58A-5.030, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 58A-5.031, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to fire safety, that threaten the life or safety of a resident; 2. Violations relating to staffing standards or	A 190		

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A 190	Continued From page 26 resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 58A-5.020, F.A.C., is documented by 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 registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a	A 190		

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A 190	Continued From page 27 class I or II deficiency or 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 or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial on-site consultant visit. 3. If a corrective action plan is required, 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 dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to fully cooperate with the agency personnel during a standard survey for a facility with a history of Class I and Class II violations,	A 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969444	A. BUILDING: _____ B. WING _____	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 190	Continued From page 28 including uncorrected Class III violations. Findings: Interviewed on at 11:00 AM residents #19, 29, 30, 31, & 32 records were requested include health assessments and progress notes due to adverse incidents being filed, the Director of Nursing only provided progress notes up to the month of , knowing that that the facility changed to an electronic format in . Interviews on at 12:49 PM the Director of Nursing stated that the facility switched to electronic records since , of 2025 and that she was very sorry she did not inform the agency during the survey. The DON stated further, "I am sorry." Interviewed on at 12:49 PM the Administrator stated that he was surprised this was not known. Interviewed on at 10:39 AM the Administrator stated that the facility provided the records requested. Class III	A 190		