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 _____	05/28/2025

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 An unannounced Relicensure, Complaint (#2025001056) and Generator Monitoring survey was conducted on - at Plaza of Hallandalle Beach. The facility had deficiencies identified related to the Relicensure and Complaint at the time of the survey.	A 000		
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 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	A 054		

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A 054	Continued From page 1 physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the Medication Observation Record (MOR) was updated immediately after each medication was administered for residents that reside in the Assisted Living. The findings include: Observation on between 8:00 AM and 8:30 AM this surveyor observed multiple empty medication cups with resident's name on top of the medication cart located at the nurse's station on the first floor. Further observation of the medication passes revealed Staff F (Medication Technician) she was observed documenting on paper MORs. At this time during an interview at 8:11AM this surveyor asked Staff F what she was documenting on the MOR. This surveyor observed no residents present at the time of Staff F documenting the MOR. During an interview on at approximately 8:35 AM Staff F stated the facility uses a laptop to conduct electronic medication passes. Staff F stated the third shift staff (11:00PM to 7:00AM) forgot to charge the tablet, Surveyor asked if it had happened before and she stated yes. Staff F confirmed documenting on paper MOR after she had administered the medications for the residents. She stated she did not know she was to immediately update the MOR after each medication was offered to the resident. She stated it is easy for her to give	A 054		

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A 054	Continued From page 2 medication first and update the MOR later. During an interview on at approximately 10:35 AM with Staff B (Facility Nurse) and Staff F. This surveyor informed Staff B and F that all unlicensed personnel must follow appropriate procedures when assisting with self-administration of medication. At this time Staff B and Staff F acknowledged the findings. During an interview on at approximately 5:15 PM team of surveyors met with the Administrator and she was informed of the findings mentioned above. She acknowledged the findings. Class III.	A 054		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to	A 056		

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A 056	Continued From page 3 another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled	A 056		

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A 056	Continued From page 4 or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medication was given to residents as ordered by the resident Physician for 1 out 3 sampled residents. (Resident #12) The Findings Included: During a medication pass observation conducted on at 8:45 AM, it was observed by this surveyor that the medication technician (Med	A 056		

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A 056	Continued From page 5 Tech) Staff E assisted Resident # 12 with his medications while he was eating breakfast. A review of Resident # 12 Medication Observation Record (MOR) on revealed that the Resident's physician had prescribed the following medication with specifics instructions. , Tab 40 MG take 1 tablet by once daily ½ to 1 hours before morning meal During an interview conducted on at 9:10 AM with Staff E (Med Tech) regarding why the Resident was given , with breakfast, she stated the Resident consistently refuses to take his medication before meals. During an interview conducted on at 3:00 PM with the Administrator, she stated that the Resident does not mind taking this medication (,) with meals. However, the Administrator acknowledged the findings after the surveyor explained the importance of following the physician's orders. Class III	A 056		
A 152	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 6	A 152		

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 observations and interview, the facility failed to provide a safe, clean, and decent living environment free of safety hazards for residents that reside at the facility. The Census at the facility on the day of the survey was 83.

The findings included:

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A 152	Continued From page 7 During a tour conducted on and between 8:00 AM and 3:00 PM, this surveyor observed the following physical plant concerns in the Memory Care Unit (MCU) and Assisted Living (AL). Memory Care Unit (photo evidence obtained) 1) # a) The resident's individual Air Conditioning wall unit had a separation alongside of the unit and wall cracks at the bottom of the unit near the wall base. Further observation underneath the unit revealed black like mold substance and paint bubbling on the wall. b) The resident's bathroom laminate floor had a surfaces and visible plank separation exposing the underlying layer located near the bathroom door. c) The resident's room laminate floor had a noticeable chipped plank exposing the underlying layer located near the resident's bed. d) Damage walls with scuff marks, unfinished stucco textures and dirty room. 2) # a) The resident's front door entrance had a laminate floor and split surface near the door threshold. b) The Resident's font door entrance at the bottom had a visible split separation from the middle hinge to the bottom hinge. c) Damage walls with scuff marks and dirty room. 3) # a) The Resident's bathroom vanity was separating from around the wall and backsplash. b) The resident's bathroom sink basin had reddish-brown stains.	A 152		

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A 152	Continued From page 8 c) The resident's bathroom wall behind the toilet had wall paint bubbling and peeling, and the baseboard between the shower and toilet pluming had a hole in the corner. d) The resident's bathroom entryway had a large piece of laminate floor plank missing. 4) # a) The Resident's wood closet door was cracked on the top of the door near the track. b) Damage walls with scuff marks and dirty room. 5) # a) inside the resident's closet ceiling tiles had a large black moldlike substance and dark brown stains. b) The resident's room laminate floor had a missing plank located near the bed. c) Damage walls with scuff marks, unfinished stucco textures and dirty room. 6) # a) The resident's bathroom sink had a hole around the sink border also rust like / reddish brown stains. b) The resident's room had approximately six ceiling tiles with large dark brown stains. c) Damage walls with scuff marks and dirty room. 7) # a) The resident's bathroom sink border had rust like and reddish-brown stains all around the sink border. b) The resident's room had approximately five ceiling tiles with large dark brown stains. c)Damage walls with scuff marks and dirty room. 8) # a) The resident's room had approximately four ceiling tiles with large dark brown stains.	A 152		

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A 152	Continued From page 9 b) inside the resident's closet the ceiling tiles had a large black moldlike substance and dark brown stains. c) Damage walls with scuff marks and dirty room. 9) # a) The resident's room had approximately two ceiling tiles with large dark brown stains. b) inside the resident's closet ceiling tiles two large black moldlike substances and dark brown stains. c) The residents closet door unable to open jammed closet doors. 10) # a) The resident's room walls had unfinished stucco textures near resident's bed and wall corners. b) The resident's dresser had damaged on the side with cracks, revealing the particle board underneath crumbling. 11) # a) The resident's room behind the front door had unfinished stucco textures. b) Damage walls with scuff marks and dirty room. 12) # a) The residents closet door unable to open jammed closet doors. b) The residents room had scuff marks walls and dirty room. 13)The facility Elevator near the front lobby was shaking, vibrating and rattling noises upon departure for each floor. Further observation revealed a control panel with cracked numbers for selecting floors (first and second floor). Furthermore, a Certificate of operation posted inside the elevator revealed that the certificate	A 152		

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A 152	Continued From page 10 was issued by the Broward County Building Code Division and documented the last inspection date of . During confidential interviews with residents revealed the elevator ride was an unsafe experience. Residents stated it was an unresolve issue that was brought up during monthly meetings. 14) Review of the facility's annual Local City Fire Inspection revealed last cleared Re-Inspection and Annual Re-Inspection #1 was dated . Further review documented Inspection Notes: Inspection of the Fire Sprinkler system was due (,). The kitchen hood system biannual inspection and exhaust cleaning was due ( ). 15)The facility dining room located on the first floor, revealed dining room entrance had unfinished stucco textures on the wall near the door. 4) # a) The residents room wall near the window was dirty with dark stains, feces like substance and body fuilds, further observation revealed approximately 4 bottles without a cap sitting on top of the air conditioning unit. b) The resident's concentrator with long house scattered on the floor by the side of the resident's bed presented a potential tripping hazard. c) Damage walls with scuff marks and dirty room. 16) # a) The residents bathroom had a wood rotten frame from the bottom to the doorknob that was in need of replacing or repairing.	A 152		

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A 152	Continued From page 11 b) Inside the residents bathroom had a laminate floor and split surface near the door. c) Damage walls with scuff marks and dirty room. 17) # a) The residents closet door had worn out rollers preventing the door from being opened. b) Damage walls with scuff marks and dirty room. During an interview on at approximately 5:15 PM the team of surveyors met with the Administrator, and she was informed of the findings of the survey mentioned above. She acknowledged the findings and the issues identified need to be repaired and corrected. Class III	A 152		
A 170	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to issue resident refund on a timely manner after discharge for 1 out of 1 sample resident (Resident #1) The findings included:	A 170		

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A 170	Continued From page 12 Record review of Resident #1 revealed she was admitted to the facility on and discharged from the facility on . Further review of Resident#1s file revealed she had a Trust Fund with the facility in the amount of $18,000.00 (eighteen thousand dollars). During an interview on at approximately 9:50 AM with the facility Administrator she was asked to confirm the discharge date and resident Trust Fund amount. At this time, she confirmed the findings. Moreover, the Administrator was asked to provide documentation of the resident's refund withing 45 days after being discharged. During an interview on at approximately 11:40 AM the facility Administrator stated she does not handle the facility refunds and it was her understanding that the corporate office took care of the matter in . At this time, she stated she needed to contact the corporate office to get approval so the resident can receive her refund . This surveyor informed the Administrator the amount was due withing 45 days after Resident #1 was discharged. During the survey process conducted between and it was revealed by record review and interviews that the resident did not receive her refund on a timely manner. During an interview on at approximately 5:00 PM the team of surveyors met with the Administrator, she acknowledged Resident #1 did not receive her refund that was due withing 45 days after she was discharged on . As evidence of the survey efforts, Resident #1 received her refund on in	A 170		

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A 170	Continued From page 13 the amount of $21,171.91 as confirmed during the interview by the Administrator. Class III	A 170		