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
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 An unannounced Relicensure, Complaint (#2025015202) and Generator Monitoring survey was conducted on & at Nena's On the Lake, LLC. Deficiencies related to the Relicensure and Complaint were identified at the time of 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 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 025		

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
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 1 (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 interview and record reviews, the facility failed to follow its admission contract policy for appropriate admission and failed to respond to a significant medical change. As evidenced by unlicensed staff delayed seeking emergency medical services ( ) evaluation for 1 of 1 sample residents(Resident #1). As evidenced of Resident #1 who was complaining of uncontrollable post , , . The resident became unresponsive and , , two hours after being transported to the hospital by .	A 025		

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
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 2 The findings include: Review of the facility admission/ discharge log indicated Resident #1 was admitted to the facility on .The resident was scheduled for plastic surgical procedures on at a surgical clinic. In an interview with the Administrator on at approximately 10 AM she stated that the facility was admitting residents that required short stay and respite care after undergoing plastic surgery procedures. When questioned about the facility's admission policy to determine the appropriateness of residents, she stated that she required the resident to be admitted a day before the planned surgical date. She stated that this allows the residents to provide demographic information, and to sign the facility contract. The Administrator stated that Resident #1 completed the demographic form, including information which indicated that she had no medical condition or and was taking no medications. The Administrator stated that Resident #1 signed the facility admission contract. Review of the facility "respite care service agreement" dated revealed the Administrator and Resident #1 signatures. Further review revealed under "medical information" section indicating "the client must submit the following at or before admission, a medical statement or clearance from a physician, nurse practitioner, or physician assistant". In a continued interview with the Administrator, she acknowledged the contract language and stated that obtaining clearances was extremely difficult. When questioned how the facility	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 3 determines the appropriateness of the residents, she stated that she only reviews the demographic information provided by the residents. The Administrator stated that the resident goes to a , , , , , at the physician clinic and the resident will get notification via text message as to an actual surgical time/ status. If the clinic determines the resident "not cleared for surgery" then the resident will not receive a text with a surgery time. She stated that she had relied on the clinic's response for appropriate admission to the facility for Resident #1. She acknowledged that she may not receive all accurate health information from the residents on their admission. She stated that it is not the facility's routine practice to take vital signs unless there is an identified symptom or complaint from the resident. Review of Resident #1's facility progress notes dated on indicated the resident returned to the facility at approximately 12 noon after being discharged from a surgery clinic. Resident #1 underwent plastic surgery procedures including "tummy tuck" and liposuction. She was prescribed , / , 5/325mg, take 2 tablets by every 6 hours as needed for , ; , 500mg by 3 x day for 7 days; 4mg 1 tab by every 8 hours for ; and , 40mg/0.4 ml syringe, take 1 syringe , every 48 hours. At the time of her return to the facility Resident#1 described her , level at score. Review of the Resident's Medication Observation Record indicated Resident #1 received , / , at 2PM and 8PM on and at 3:18AM on . No	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 4 other medications were indicated as taken on the record. In a continued interview with the Administrator, she stated that Resident #1 had ambulated numerous times with assistance to the bathroom and she had consumed soup and hydration fluids with no issues. The Administrator stated that Resident#1 was complaining of , and was educated about the healing process after surgery. The Administrator stated that Resident #1 described her , as between score and the prescribed medication had been provided as ordered by the physician. Review of Resident #1's facility progress notes on from 1PM to 3:18AM on revealed the resident was monitored hourly by the facility staff. The notes indicate Resident#1 described her , level at score level thru the evening and was observed to be asleep/ resting. Further review of the progress notes dated 3:18AM, Resident#1 was found awake and complained of , at a level of score. medication was given at that time. Further review of the progress notes dated at 7AM revealed facility staff received a call from other residents that Resident #1 was in , . The Administrator responded and the resident expressed she had uncontrolled , and had a "low" threshold for , . The Administrator suggested Resident#1 should go to the emergency room (ER) to evaluate the , . The note indicates the Administrator calls Resident#1's family, who was identified on the demographic form, to inform that Resident#1 would be going to the ER. The note does not indicate that the Administrator attempted to contact the physician or call 911 for medical	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 5 evaluation. No vital signs were documented. In a continued interview with the Administrator, she stated that Resident #1 had refused breakfast and verbalized numerous times she "wanted to see her physician" to evaluate the , . The Administrator stated Resident#1 was ambulatory, but she placed her in a wheelchair and wheeled her outside to the Administrator's vehicle. The Administrator stated she did not call 911 for evaluation until the resident became unresponsive. Further review of the progress notes dated 7:41AM reveals Resident #1 is assisted to Administrator's vehicle and while attempting to get into vehicle the resident appeared to faint, into the Administrator's arms. Resident#1 becomes unresponsive, and the Administrator places the resident on the ground and calls 911. The note indicates Resident#1's , was faint; the Administrator begins - ( ). Emergency medical services ( ) personnel arrive and transport Resident#1 to the hospital for evaluation. In a continued interview with the Administrator, she stated that after Resident#1 was transported to the hospital, she received a phone call from another member of Resident #1's family who was verbally upset and questioned who had approved Resident #1's surgery since she had a concerning past medical history. The Administrator stated she was unaware of any medical history since Resident #1 had indicated she had "none" on the admission form. The Administrator stated that she had not taken any vital signs throughout the admission since she had not observed any concerns prompting measurements. The Administrator stated she was a trained home	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 6 health aide and trained to take vital sign measurements. She acknowledged that she is not a licensed medical professional. The Administrator stated that she made attempts to call Resident#1's physician and the facility's owner after the resident was transported to the hospital. The Administrator stated that she received a phone call around 10:41 AM from Resident#1's family member notifying that the resident had , in the hospital. Review of Resident #1's hospital records dated indicated the resident was transported by to the emergency room, arriving at 8:21 AM. The resident was assessed to be in and emergency care was implemented. The record indicates the resident was pronounced at 10:18AM. Medical clinical impression included: , failure, severe , , , and , , . Resident #1 entered in a contract with the facility to provide appropriate personal care and services. The resident developed a change in medical condition while recovering after surgery and required assistance in obtaining access to appropriate health care. Unlicensed facility staff made the decision to drive the resident to the hospital. was called when Resident#1 became unresponsive while getting into the staff vehicle. The facility failed to contact immediately upon the resident exhibiting signficiant health changes due to the complications from the surgery. Medical services for Resident #1 were delayed over 45 minutes upon notification to the Administrator. Medical services were not rendered to the resident until the resident became unresponsive and were called.	A 025		

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
	AL11969196	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NENA'S ON THE LAKE, LLC	8140 NW 47TH CT LAUDERHILL, FL 33351

(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 025	Continued From page 7 Class II	A 025		