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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 Complaint survey, #2025014309, #2025002845, #2025005888, #2025007824 and #2025010795, was conducted at Midtown Assisted Living Residence on - . The facility had deficiencies related to complaint #2025007824 at the time of the survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The	A 030		

AHCA Form 3020-0001

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

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 1	A 030		

telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and
, ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 2 must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or	A 030		

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 3	A 030		

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 4 resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 5 resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record, observation and interview, the facility failed to take timely and decisive actions to ensure the safety and welfare of residents in the facility after demonstrated acts of aggression/or assaults by other resident (Residents 1 and 3). As such, all remaining 99 residents (Resident#2, #4-#101) residents of the facility were at risk for resident to resident verbal and , , . In	A 030		

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 6 addition the facility failed to ensure a safe living environment for all residents residing at the facility by ensuring appropriate supervision for all residents based on their status and mental health diagnosis. The Findings Include: A review of the facility's Resident Agreement documented: No Resident of the facility shall be deprived of any civil or legal rights, benefits or privileges guaranteed by law, the constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of the facility shall have the right to: a). Live in a safe and decent living environment, free from and neglect. b). Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. The facility census on the day of the survey was 101 residents (Resident #1-101), including Resident #1 and #3). Further review of the facility license revealed they were licensed as a Limited Mental Health Facility. The facility is responsible for providing care and services including additional supervision to residents that suffer from mental health illness (with documented diagnosis). Review of facility documents and residents' files also showed various incidents involving residents that reflected a lack of supervision and intervention to protect the wellbeing safety of the victim(s) and other residents residing in the facility. 1) A review of the Resident 3's Health Assessment form (AHCA form 1823) dated documented his diagnosis as:	A 030		

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
	AL11910711	A. BUILDING: ____ B. WING ____	10/02/2025

NAME OF PROVIDER OR SUPPLIER: **MIDTOWN ASSISTED LIVING RESIDENCE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2001 POLK STREET, HOLLYWOOD, FL 33020**

(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 030	Continued From page 7 , Unspecified, of , Generalized , and Idiopathic , Major , Recurrent, Other , Unspecified Organism, , Unspecified Injury of , Unspecified , Unspecified Not Due to A Substance or Known Physiological condition. It also documented his Activities of Daily Living (ADLs) as Independent with Ambulation, , Eating, Grooming, Toileting, Transfer. And Supervision with Bathing. A review of Resident 4's AHCA form 1823 dated documented his diagnosis as: , Hyperlipemia. It also documented that he is Independent all his Activities of Daily Living (ADLs). A review of Resident 4's AHCA form 1823 dated documented his diagnosis as . It also documented that he is Independent in all his Activities of Daily Living (ADLs). A review of a facility Incident Report dated at (no time provided) documented the following: "(Resident #3) started a argument with (Resident #4) by calling him a [vulgar and racist word(s)] and other slander words till (Resident #4) couldn't take it anymore so he insulted at him and apparently hit (Resident #3) in the leading to short term but ended up being okay." (copy obtained). A review of Resident #4's facility file revealed a letter on the facility's letterhead dated	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 8	A 030		

that documented (Resident #4) was hit in the , treated by local at the facility, but was not taken to the hospital. Documentation in the Resident's file revealed photos of the incident/injury (copies obtained).

In an interview with Resident #4 on at 3:37 PM he stated he was hit in the with some kind of object (not stabbed) by Resident #3. He stated he was waiting for his medicine by the Nurses' station and Resident #3 stuck his middle in his . He stated he hit Resident #3, then he (Resident #3) came and hit him in the with a metal cross.

A review of Resident #3's facility file documented he was admitted to the facility on . A review of the Resident's Progress Notes revealed he began exhibiting aggressive behavior toward other residents/or staff on and continued until he was on . Relative to the Resident's aggressive action/behaviors, a review of his facility Progress Notes revealed the following:

a) at 10:10 AM: (Resident #3) and another resident entered a residents room without permission (it is believed that he was attempting to steal) Resident #3 appeared surprised when he saw the other resident sitting on the bed. When the resident asked why they were in the room (another resident) pushed the resident down. When the resident got up (Resident #3) then pushed the resident down again. Police were called. Since then the verbal threats and harassment have continued.

b) Update: ED spoke to (Resident #3) he admitted to hitting the resident in the and drawing . When asked why he did it he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 9 stated that the guy is a pedophile and that's why he done it. ED asked (Resident #3) how he know he the guy was a pedophile and (Resident #3) stated he is. Resident will be given a 45 day notice and parents will be notified. c) at 5:44 PM: Yesterday evening (Resident #3) got into a physical fight with (Resident #7). All day (Resident #3) was chasing and bullying (Resident #7). ED told (Resident #3) to leave (Resident #7) alone may times. After ED left, ED received a call that (Resident #3) and (Resident #7) had gotten into a fight. (Resident #3) cornered (Resident #7) and pushed him. d) at 4:51 PM: Resident was very aggressive with med tech staff. He accused them of talking about his family and began shaking the medcart. e) 0/11/2024 5:02 PM: Resident continues to pick on another resident who he previously got into a fight with. (Resident #3) stated the resident is stealing from people and he believes he is the one to handle this. (Resident #3) was told to leave the resident alone. f) at 2:18 PM: ED received a call from (local Behavioral entity). (Resident #3) was due to . He told them he had a razor and planned to stab [Resident name] who recently got together with (Resident #3) g) at 11:43 AM: Resident continues to bully another resident because of (Resident #3's) Ex. The other resident was told he has a right to defend himself against (Resident #3). (Resident #3) has been told multiple times to leave this resident alone but he continues to mess with him.	A 030		

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 10	A 030		

h) at 3:22 PM: ED spoke to the resident and a staff member. (Resident #3) is walking around bullying other residents and telling them to "[profanity language]." This morning a resident was at the front desk speaking with staff members when (Resident #3) randomly walked by and told him to shut "[profanity language]".

i) at 6:42 PM: Yesterday during evening med pass (Resident #3) threw a plate of food on the medtech. He asked for a plate of food and the medtech gave him the plate he then proceeds to call her a [profanity language]and threw the food at her. Resident was told to go to his room.

j) at 6:42 PM: Today during med pass, (Resident #3) hit the medtech on the arm after calling the other medtech a "[profanity language]". No injuries reported. (Resident #3) wanted a plate of food but it was not time for snack so he proceeded to verbally medtech then reach out and hit her on the arm.

k) at 6:42 PM: So from my understanding, the floor was being mopped by another resident. (Resident #3) purposefully walked on the floor and called the resident the "N word and faggot". The resident asked (Resident #3) to leave him alone but (Resident #3) continued with the racial slurs and name calling. (Resident #3) them squared up with the guy and said he wanted to fight him.

l) at 11:06 AM: Late Entry for 12:00 PM: Resident got drunk. Could not properly function and was told to stay in his room for the remainder of the day.

m) at 10:54 AM: Late Entry for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 11 at 6:00 PM: Resident was caught smoking marijuana inside his room. The pipe and plant was taken from him. (Resident #7) defended himself and pushed (Resident #3) down and kicked him. The fight ended and (Resident #3) continued to try and fight (Resident #7) but staff was able to break them up. n) at 10:06 AM: Late Entry for 5:00 PM: Resident walked by another resident (Resident #4) and hit him on the with a metal pipelike object for no apparent reason. The two began to scuffle until the fight was broken up. (Resident #4) suffered a to his but no emergency treatment was necessary. Police were called and (Resident #3) was . o) at 2:19 PM: Resident was readmitted to Midtown. Contract from previous admission is still in place. As reflected in Resident #3's Progress Notes (above), the Resident had a documented history of aggressive behavior toward other Residents and staff of the facility but remains at the facility. A review of the Resident 3's facility file and documents revealed that he has a documented history of aggression/behavior/actions toward other residents/or staff. However, he was allowed to return to the facility on following release from his incarceration for assaulting another resident. The facility had not implemented interventions and/or procedures to protect the remaining residents and staff at the facility against Resident #3'aggressive behavior. The facility continued to allow Resident #3 to congregate with other	A 030		

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 12 residents and staff at free will, jeopardizing the safety of all. 2) In an interview with the Administrator during the survey on at 9:47 AM he informed this surveyor of an incident involving Resident #1. He stated the Resident had just assaulted a female Resident (Resident #8) while sitting on the patio. He stated the female resident (Resident #8) was sitting next to him and did not do anything to him. Resident #1 just jumped up a threw a soda at her, then an ashtray, then hit her with another ashtray. This surveyor asked if he was still at the facility and he said yes, and that Resident #1 was under a 45-day notice. This surveyor informed/or reminded him the of regulation regarding terminations in situations where a facility deemed the actions of a resident put other residents at risk for assault/violence. He acknowledged and stated the language was in their Resident Agreements. A review of Resident #1's facility file and documents revealed Progress Notes documenting the following: a) at 3:14 PM: Late Entry for 4:46 PM: At approx. 446pm on (Resident #1) got into a physical altercation with another resident. Camera footage was captured. In the footage it showed another resident unintentionally bump (Resident #1). (Resident #1) then begins to yell at the other resident. When the resident attempted to walk out the front door (Resident #1) hits the other resident. The resident then pushes (Resident #1). (Resident #1) then the resident and pushes him to the ground.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 13 b) 11:15 AM: Late Entry for 12:00 PM: Resident continues to yell and scream at med tech because he believes his med are messed up. He was told many times to not yell at med techs and to approach the situation respectfully. Resident admitted to yelling at staff. c) 10:30 AM: This morning (Resident #1) "went off" on a housekeeping staff member stating he wanted to his laundry own in the facility laundry room. He was told there are specific times and dates for laundry and a resident is not allowed to do their own laundry on facility premises. (Resident #1) then ripped down the laundry schedule off the wall and put it in the of the staff member. (Resident #1) then made remarks against the ED stating "if he wants war, we can have a war. It'll be Iran vs Israel." d) at 5:29 PM: Resident continues to yell and berate staff. Residents 45 day have passed and behavior has not changed. e) at 9:52 AM: Resident continues to be disrespectful to med techs .... Residents 45 day notice is up and as a courtesy ED has chosen not to evict resident but his behavior is unacceptable. Now 3 hours later-Resident is now threatening ED. Slandering ED stating ED is "not a good man and he will pay for this." The facility had not implemented interventions and/or procedures to protect the remaining residents and staff at the facility against Resident #1'aggressive behavior. The facility continued to allow Resident #3 to congregate with other residents and staff at free will, jeopardizing the safety of all. While the facility may decide to retain residents	A 030		

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 030	Continued From page 14 who have engaged in a pattern of conduct that is harmful or offensive to other residents; or who have committed assaults/or acts of aggression against another residents or staff, doing so places all residents and staff at risk of experiencing similar actions. At the time of the survey, Residents #1 and #3 who are documented as having engaged in such conduct, were still residents of the facility, thus placing all residents of the facility at risk for similar conduct. No additional information was provided during the survey. Class II	A 030		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage;	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 165	Continued From page 15 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 165	Continued From page 16 determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to submit/or timely submit an Adverse Incident Report (AIR) to the Agency as required following an incident involving physical harm from resident to resident in which local law enforcement was involved. The Findings Include:	A 165		

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
	AL11910711	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

(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 165	Continued From page 17 A review of the facility file and documents revealed an incident on 5:00 PM in which Resident #3 physically assaulted Resident #4. A review of Resident #3 facility Progress Notes document an entry as follows: at 10:06 AM: Late Entry for 5:00 PM: Resident walked by another resident (Resident #4) and hit him on the with a metal pipelike object for no apparent reason. The two began to scuffle until the fight was broken up. (Resident #4) suffered a to his but no emergency treatment was necessary. Police were called and (Resident #3) was . In an interview with the Administrator on at 1:15 PM this surveyor made a request for the Adverse Incident Report related to the incident involving Residents 3 and 4. He stated an AIRs was not submitted. This surveyor reminded him of the requirements for submitting the AIRS to the Agency. Specifically, an event that is reported to law enforcement or its personnel for investigation. He acknowledged. Class	A 165		