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
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 Initial Extended Congregate Care (ECC) and Generator Monitoring survey was conducted on at Meadowview Progressive Care II. The facility had deficiencies related to the Extended Congregate Care (ECC) and Generator Monitoring.	A 000		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 1 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 2 administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 3 at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on interview observations and record review, it was determined that the facility Administrator failed to ensure supervision within the facility, failed to provide appropriate care for Resident #1, and failed to manage facility staff, for 1 out of 1 sampled residents(Resident #1). The findings included: The survey team arrived at the facility on at approximately 12:50 PM to conduct an initial Extended Congregate Care and Generator monitoring survey. Surveyors proceeded to knock on the door and nobody answered. The surveyor made a call to the Administrator, during a conference call interview on at 1:10 PM the Administrator was informed surveyors onsite for an Extended Congregate Care (ECC) licensure compliance survey. The Administrator stated there was nobody at the facility. At the time, he confirmed the facility has only one resident (Resident #1) that was also under the ECC specialty license. When asked to see Resident #1 and gain access to the facility, the administrator stated the resident was out with a staff member on an outing. He was informed to provide information about the whereabouts of Resident #1 (name of the place, name and phone number of the staff). He stated he did not know where the resident was and was	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 4 not able to provide the name and phone number of the staff that took Resident #1 for an outing. Team of surveyors reported the findings immediately to the "Agency" Agency for Health Care Administration (AHCA) supervisor. Due to Agency intervention the Administrator returned to the facility. During an call placed to the Administrator by the Supervisor (with the team on the line), the nature of the visit was explained again. The Administrator was also informed that he was required to grant access to AHCA at all times and denial of access is not acceptable. He stated, he wanted us to come , we reminded him the visit are unannounced and that we need to gain access to the program to conduct the survey. The Administrator finally agreed and stated he was on his way. The Administrator arrived at the facility during an interview on at approximately 2:30 PM (after extended daily by the Administrator). Upon arriveal of the Administrator, a second request was made to provide information about the whereabouts of Resident #1 and the facility staff (unknown name). He was informed to provide facility staffing schedule, facility roster for direct care staff members with name(s), titles and phone numbers and ECC training (Administrator and direct care staff). During facility record review it was revealed that the facility did not have staffing schedule and Staff files readily available for review. During an interview on at approximately 2:45 PM the Administrator was informed to provide the following documentation	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 5 for Resident #1: a) complete file (administrative and medical). b) services and care plan provided to Resident #1 under the ECC specialty license. c)Medication Observation Record (MOR) Record review of Resident #1 revealed that the facility did not have complete file (administrative and medical), services and care plan under the ECC specialty license. Further review revealed the facility had a MOR for review but no medication onsite. An observation during tour on between 2:30 PM and 4:20 PM revealed the facility does not have the key for the medication cart (storage of resident medication). During an interview on at approximately 2:58 PM the Administrator stated the staff (unknown name) has the key. He stated he could not conduct a medication audit with the Agency Nurse surveyor because the medication cart key we not available. During an interview conducted on at 3:15 PM with the Administrator and the Agency Nurse surveyor. He stated he is the facility owner and holds a license as Advanced Practice Registered Nurse (APRN). The Agency Nurse surveyor again inquired about the whereabouts of Resident #1. The Administrator stated that the resident was in a day care program and provided the name. However, he could not provide a contact phone number for that program. After a few minutes, the administrator then stated that the resident was currently with staff possibly at the mall. At this time, the situation was confusing, and the administrator was asked to clarify the whereabouts of Resident #1 (at the mall with staff	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 6 or at a day care program). At approximately 3:45 PM the Administrator stated he was leaving to pick up Resident #1 (unknown location). Several attempts were made by the team of surveyors to the Administrator to disclose the location and name of the staff that was with Resident #1. No information was provided, the Administrator refused to answer the question . At approximately 4:25 PM on , the Administrator returned to the facility with Resident #1 and no staff member (unknown name). During an interview conducted on at 4:27 PM with Resident #1 and the Agency Nurse surveyor, revealed Resident #1 seemed and out of place and then stated, "this is a nice house" unable to conduct the interview (it was difficult to understand what Resident #1 was saying due to speech ,). During an interview conducted on at approximately 4:30 PM Team of surveyors met with the Administrator. He was given an opportunity to disclose the whereabouts of Resident #1 and the name and phone number of the staff that took the resident for an outing. At this time, he stated he owns a group home, and he thinks Resident #1 was brought there by the staff (unknown name). No further information was provided. The Administrator was reminded the facility must be under the supervision of an Administrator (him) and responsible for the operation of the facility including management of all staff and responsible for appropriate care to all residents that reside at the facility. During a further interview with the Administrator	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 077	Continued From page 7 on at around 5 PM with the ALF Supervisor (by phone) and the surveyor team(on-site), the location of the resident was requested again. The Administrator was also asked why the staff member didn't return with the resident. The Administrator stated after over 5 hours of communication with the surveyors that he runs an ADP group home and the resident was at that location. The Administrator intentionally provided inaccurate information to the survey team throughout the survey until area office intervention (with the ALF Supervisor). He stated the resident lives between both locations. The Administrator was asked why was the resident under two different programs at two different locations. The Administrator was unable to provide an explanation. The Administrator was also unable to verify that the resident was given an opportunity to reside freely at the ALF and not forced to another location. Class II	A 077		
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, 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	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 152	Continued From page 8 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 resident(s). The findings included: During a tour conducted on between 2:30 PM and 4:20 PM, team of surveyors observed the following physical plant concerns (photo evidence obtained). 1) Common area a) Florida room ceiling had large areas with	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 152	Continued From page 9 brown spots and black mold like stains. b) the ceiling had exposed large areas with patched drywall material (unknown material) that was used to cover most openings on the ceiling (unfinished/incomplete drywall work). The ceiling was in state of disrepair. c)debris was observed to be scattered on the floor. During an interview with the Administrator on at approximately 2:55 PM he stated the roof had a leak and he was working with the insurance company for repairs. He was informed to provide any document(s) paper and/or electronic information that supports the facility is actively working with the insurance company and/or repairs. 2) Kitchen a) stainless steel like stove control panel; had discoloration with like marks (heat like damage), black spots and grease stains. 3) Dining table a) approximately 2 black and brown chairs with leather like covering (seat base was from the chair frame). 4) Bathroom (hallway) a) the outer wall of the shower (near toilet) had a section of missing approximately 12 tiles (small tiles). During an interview on at approximately 4:40 PM the Administrator met with the team of surveyors and he was informed of the concerns mentioned above. He was giving an opportunity to provide any documentation to support the facility is actively working with the insurance company and/or repairs. No additional	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 152	Continued From page 10 information was provided. Class III	A 152		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of .	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 160	Continued From page 11 (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 160	Continued From page 12 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that, the facility failed to maintain required facility records onsite and readily available for review. The findings included: During a conference call interview on at 1:10 PM with the Administrator, he confirmed the facility had only one resident under an ECC license.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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 160	Continued From page 13 During an interview on at approximately 2:30 PM the Administrator was informed to provide the following documentation for review during the Specialty Licensure survey: 1.) Up-to-date Admission and Discharge log listing, documenting date of admission for Resident #1 and facility or place where resident was admitted. 2.) Admission package (copy of what was given to Resident #1, indicating what the service plan for ECC care was). 3.) Facility Policy and Procedures for ECC and Staff Files 4.) Resident #1 service plan (nursing assessment and nursing progress notes if applicable) 5.) The Facility's Medication Practices (facility's policy and procedures and /or protocol) During facility record review it was revealed that the facility did not have all the documents requested above for review during the survey process. Further review revealed facility Provisional License for ECC expired on During an interview on at approximately 4:40 PM the Administrator acknowledged the facility did not have readily available all the documentation mentioned above during an ECC Specialty License survey. No additional documentation was provided during the survey. Class III	A 160		
AE200	59A-36.021(1); 429.07(3)(b)4 ECC - Licensing 59A-36.021(1) LICENSING.	AE200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
AE200	Continued From page 14 (a) Any facility intending to establish extended congregate care services must obtain a license from the agency before accepting residents needing extended congregate care services. (b) Only the portion of a facility that meets the physical requirements for extended congregate care in Chapter 4, Section 464 of the Florida Building Code as adopted in Rule 61G20-1.001, F.A.C. and is staffed in accordance with subsection (3), is considered licensed to provide extended congregate care services to residents who meet the admission and continued residency requirements of this rule. 429.07(3)(b) 4. A facility that is licensed to provide extended congregate care services must: a. Demonstrate the capability to meet unanticipated resident service needs. b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule. c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency. d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or . e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking. f. Implement the concept of managed risk. g. Provide, directly or through contract, the	AE200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
AE200	Continued From page 15 services of a person licensed under part I of chapter 464. h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to adapt and follow policies and procedures of the Extended Congregate Care (ECC) licensure evidenced by not promoting a homelike setting, not providing sufficient staff, and failed to meet the resident service needs for 1 of 1 resident reviewed for ECC services (Resident #1). The findings included: On at 1:10 PM an Extended Congregate Care (ECC) licensure compliance survey was conducted. According to the Administrator, the facility only has one resident, Resident #1, and he's receiving ECC services. When asked to see Resident #1, the administrator stated the resident was out with a staff member on an outing. During a tour of the facility conducted on at 3:00 PM with the Administrator, who stated the facility's capacity is 6 residents, 2 private rooms and 2 semi-private. The tour revealed a few environmental concerns in the residents' rooms including cables hanging, unpainted walls and scoffed furnishings. The kitchen appeared unused and dirty. The stove was stained with an over-the-stove microwave, which was not working (as per the administrator, that was why there was another microwave on the counter). There were very little food items in the refrigerator and in the cabinets. The office/family room's ceiling had	AE200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
AE200	Continued From page 16 holes and some of them were patched up. The administrator stated that there was some water damage and he was getting the whole roof fixed. Off the office/family room, there was another room (with a bed and other furnishings). The administrator stated that the room is not used. When asked what his plans for the room were, he stated he was not sure, maybe staff can stay there overnight. Overall, the facility appeared uninhabited with a musty odor and no staff members were in the building. Review of the staff records revealed all staff had the required ECC training, however, this was not verified by the staff since there were no staff currently at the facility. Further review revealed no contact information or job application for any of the staff except for one. A phone call interview with this staff was attempted, however, no response and voicemail was left with contact information. This staff member never called . Review of the facility's ECC binder provided to the surveyors revealed Resident #1 as currently participating in the program. This binder contained Resident #1's Health Assessment form (AHCA form 1823) which documented that the resident was admitted to the facility on with diagnoses that included: , , , , . Resident #1's nursing requirements were to assist with Activities of Daily Living (ADLs) and medication management which included special precautions to monitor medication side effects, , , and behavioral issues. Further review of Resident #1's AHCA form revealed it was signed by the physician; however, it was not dated. When inquiring about the date of the 1823 form, the administrator walked away	AE200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
AE200	Continued From page 17 with the ECC binder. He then returned with his phone showing the calendar with a doctor's , , on , but the resident's name was not on it. Then, the administrator again walked away. This surveyor asked for Resident #1's ECC binder and 1823 form . The administrator returned with the binder, and it was noted that he had added the date ( ) to the bottom of the 1823 form. Review of Resident #1's initial nursing assessment dated revealed no family/representative contact information and the administrator was listed as the resident's emergency contact. In addition, the nursing assessment documented that Resident #1 can ambulate and transfer independently, uses the toilet and able to self-groom. There was no other nursing assessments noted since . The administrator was asked for Resident #1's individualized service plan. He again walked away with the binder, returned a few minutes later with an Annual Community Living Support Plan dated (which was added to the binder after the administrator was asked for a service plan). Further review of the ECC binder revealed no progress notes for Resident #1. According to the administrator, he keeps all progress notes on the computer, which currently was not in the facility. In addition, the administrator was unable to provide the Medication Observation Record (MOR) or Resident #1's medication. He stated that the medications and the MOR were in the locked cabinet and he does not have the key at this time. During an interview conducted on at 3:15 PM with the administrator who stated he is the owner and a nurse practitioner. The surveyor again inquired about the whereabouts of Resident	AE200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
	Continued From page 18	AE200		

#1. The administrator stated that the resident was in a day care program and provided the name, however, could not provide a contact phone number for that program. After a few minutes, the administrator then stated that the resident was currently with staff possibly at the mall. At this time, the situation was confusing, and the administrator was asked to clarify the whereabouts of Resident #1 (at the mall with staff or at a day care program).
After further discussion of the whereabouts of Resident #1, the administrator became very nervous and agitated. He stated he was unable to contact the staff member, because the phone numbers for staff were not working, then he stated he was supposed to pick up the resident a while ago and was delayed by this survey. He was again asked where he was going to pick up Resident #1, he then stated the resident is out in the community with a staff member. He kept pacing nervously around the office/family room and at one point he went out the front door entrance of the facility. At 3:45 PM the administrator appeared very agitated and stated he was going to go pick up Resident #1 and the staff member. The administrator left and returned to the facility at 4:25 PM with the resident, but with no staff member.

During an interview conducted on at around 4:27 PM with Resident #1, who was observed to be ambulating independently without an assistive device entering the facility. He was dressed in a clean button-down shirt and a pair of jeans. He stated he had lunch, something about beans (it was difficult to understand what the resident was saying due to speech ,). The resident seemed and out of place and then stated, "this is a nice house". At this time, the administrator was very jumpy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
AE200	Continued From page 19 nervous and refused to further explain whether Resident #1 lived at the facility. The Administrator also failed to provide an explanation of the location of the resident . During a further interview with the Administrator on . . at around 5 PM with the ALF Supervisor (by phone) and the surveyor team(on-site), the location of the resident was requested again. The Administrator was also asked why the staff member didn't return with the resident. The Administrator stated after over 5 hours of communication with the surveyors that he runs an ADP group home and the resident was at that location. The Administrator intentionally provided inaccurate information to the survey team throughout the survey until area office intervention (with the ALF Supervisor). He stated, the resident lives between both locations. The Administrator was asked why was the resident under two different programs at two different locations. The Administrator was unable to provide an explanation. The Administrator was also unable to verify that the resident was given an opportunity to reside freely at the ALF and not forced to another location. Class III	AE200		

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
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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
	AL11970489	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW PROGERESSIVE CARE II	9440 JOHNSON ST PEMBROKE PINES, FL 33024

(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
ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure its Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the Local County Emergency Management Division. The findings included: During an interview with the Administrator on between 2:30 PM and 4:00 PM, a request was made for the facility's current CEMP approval letter and / or all communications and submissions regarding the CEMP. A review of the facility's record revealed it did not have a copy of the most current CEMP approval letter in file. The file failed to reflect any submissions of the CEMP to the County. Review of Broward County website revealed no documentation of submission of a CEMP. During an interview on at approximately 4:40 PM the Administrator met with the team of surveyors and acknowledged the facility did not have a CEMP approval letter at the time. No additional information was provided. Class III	ZZ830		