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
	AL11968532	A. BUILDING: _____ B. WING _____	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENGLAND'S PLACE LLC	5520 BUCHANAN STREET HOLLYWOOD, FL 33021

(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 with Extended Congregate Care (ECC) and a Generator Monitoring survey was conducted at The England's Place LLC. on . The facility had deficiencies identified at the time of the visit.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that the Medication Observation Record (MOR) was signed immediately after assistance was provided to one of five sampled residents (Resident #3) by facility staff. The findings included: Resident #3, an adult male admitted to the facility on , as documented in the Admission Records (Sheet). Resident #3's Health Assessment, (AHCA Form 1823), dated documented Resident #3 required assistance with self-administration of medications. On at 12:20 PM, Staff B(Direct Care Staff) assisted Resident #3 in taking 20 mg. However, Staff B did not use the MOR during the process. Staff B failed to document the administration in the MOR or sign the record as required. During the exit meeting held on at 3:00 PM, the issue was discussed with Staff A and Staff B, both of whom acknowledged the findings. The Administrator was informed of the deficiency and confirmed that corrective measures will be implemented to address the concern. Class III	A 054		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders	A 056		

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A 056	Continued From page 2 (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by	A 056		

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A 056	Continued From page 3	A 056		

the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S.,

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A 056	Continued From page 4 before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined that, the facility failed to ensure that unused medication belonging to one of five sampled residents (Resident #4) was properly discarded or returned to the pharmacy. Th findings included: On . , at 12:30 PM, a review of medications stored at the facility revealed that , , 2.5 mg, prescribed at one tablet daily and dated , , was partially used. The pre-packaged , pills were found behind a medication basket which contained Resident #4's current medications. The pre-packaged bubble pack had three pills missing out of 30. Review of Resident #4's Medication Observation Record (MOR) showed no evidence that , , 2.5 mg was among the resident's current medications. At 12:15 PM, on , Staff B (Direct Care Staff) confirmed during an interview that Resident #4 was no longer taking , , 2.5 mg and stated she was unaware the package was stored behind the medication basket. The Administrator was informed of the concern and acknowledged that the pills had been	A 056		

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A 056	Continued From page 5 overlooked. She confirmed that corrective action will be taken to ensure proper disposal of the unused medication. Class III	A 056		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed	A 093		

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A 093	Continued From page 6 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide	A 093		

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A 093	Continued From page 7 notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, it was determined that 1 of 1 sampled resident (Resident #4), who required a pureed diet, was served a meal that did not meet the standards outlined in the current USDA Dietary Guidelines.	A 093		

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A 093	Continued From page 8 The findings include: On . , at 11:50 AM, Staff A was observed preparing Resident #4's lunch. Staff A confirmed that Resident #4 required a pureed diet, as documented in the resident's health assessment record (AHCA Form 1823). To prepare the meal, Staff A blended broccoli, potato, mixed vegetables, and meatballs together with milk in a small blender. The resulting mixture was a pureed meal that lacked identifiable components of the original menu items. Staff A subsequently entered Resident #4's bedroom and served the meal without informing the resident of its contents. Review of Resident #4's health assessment record (AHCA form 1823 dated) documented Resident #4 had a diagnosis of . Resident #4 required a regular pureed diet. . At approximately 9:40 AM the same day, the Surveyor attempted to interview Resident #4. The interview was unsuccessful, as Resident #4 is non-verbal and does not use gestures to communicate needs, preferences, or understanding. The findings were discussed with the Administrator during the exit meeting at 3:00 PM on . . The Administrator acknowledged the deficiency and stated that corrective action would be taken. CLASS III	A 093		