

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435			
(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 investigation (complaint numbers 2025004913 and 2025004565) was conducted at Parkside Inn on . The facility had deficiencies at the time of the survey.	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 (1) ADMINISTRATORS. Every facility must be	A 077			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435		
(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 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 administrator must:	A 077			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435		
(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 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 at:	A 077			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435		
(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 http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations and staff interviews, it was determined that, the facility did not have an officially designated manager in charge during the Administrator's absence. The lack of formal managerial delegation had the potential to affect the care of all 36 residents. The findings include: On at 9:00 AM, a complaint investigation was initiated at the facility. Upon entry, Staff A (Acting Manager) was observed seated at the front desk. When asked to notify the Administrator of the survey, Staff A stated that the Administrator was not present. When questioned further regarding who was in charge and how long the Administrator had been absent, Staff A responded that she was acting in charge and that the Administrator had not been at the facility for one week. Additional inquiry revealed that Staff A had not been officially designated as the manager in charge, despite assuming that responsibility. When asked whether she was CORE-trained, Staff A replied "No." During interviews with multiple staff members (Staff B, C, and D) conducted between 9:40 AM and 10:00 AM on , all confirmed that the Administrator had been absent from the facility for exactly one week. At 11:45 AM the same day, the Administrator was contacted by telephone and confirmed that Staff A was serving as the person in charge. However,	A 077			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435		
(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 when asked whether a formal designation had been made, the Administrator acknowledged that it had not been officially documented, stating that she was ill at home and intended to formalize the upon her return. Class III	A 077			
A 180	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964 . The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml . The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an	A 180			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN			STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435		
(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 180	Continued From page 5 emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with _____'s or related _____, and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain an approved Comprehensive Emergency Management Plan (CEMP), as required to ensure the safety of the 36 out of 36 residents of the facility. The findings include: On _____ at 11:45 AM, the Administrator of the facility was asked to provide evidence of their approved Comprehensive Emergency Management Plan (CEMP). She stated that the plan was not yet approved. The Administrator further explained that due to change in the county's emergency plan processing their plan submission was delayed. Review of the facility's previously approved CEMP showed it expired _____. The _____.	A 180			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910357	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER PARKSIDE INN		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW 3RD ST BOYNTON BEACH, FL 33435			
(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 180	Continued From page 6 last resubmission of the emergency plan was on During the exit meeting, the Administrator did not provide any additional information. Class III	A 180			