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
	AL11970434	A. BUILDING: _____ B. WING _____	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE HALLANDALE LLC	105 SW 4TH ST HALLANDALE BEACH, FL 33009

(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, complaint #2025010773 was conducted at Prestige Care Hallandale LLC, on . The facility had deficiencies at the time of the survey. The complaint was substantiated and cited at A0025.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on a review of the facility's elopement and supervision policies, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent the elopement of, 1 of 1 sampled resident (Resident #1). The findings included: The facility's elopement policy defines elopement as "leaving the premises without permission or notice" and states that the Administrator or designee must be aware of all residents identified as high risk for elopement.	A 025		

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A 025	Continued From page 2 Review of an incident report dated , from an unnamed source, documented that Resident #1 was found six blocks away from the facility on . According to the report, the resident was located by law enforcement, appeared , and had on her . However, review of the facility ' s incident log revealed no documentation of this event, as the log was blank. Review of Resident #1's admission records on , indicated that the resident was admitted on . The health assessment record (AHCA Form 1823), dated , documented diagnoses including , ( ), and . Section I of the assessment indicated that Resident #1 was not considered at risk for elopement but did require assistance with ambulation. During an interview on , at 10:30 a.m., the Administrator stated that on the date of the elopement, Resident #1 had been sitting on the porch with a staff member. The Administrator reported that Staff C briefly left the resident unattended to address another matter. Upon returning, the resident could not be located. Staff conducted a search of the facility and surrounding property, followed by a search of the neighborhood, but were unable to locate the resident. The Administrator said when he arrived at the facility, he too assisted with the search to no avail. Law enforcement was subsequently contacted. The facility was later informed that Resident #1 had been found and transported to a nearby hospital by the police. The resident was later returned to the facility safely.	A 025		

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A 025	Continued From page 3 An interview with Staff C on , , at 8:50 p.m. confirmed that Resident #1 had been on the porch with two other residents at the time of the incident. Staff C corroborated the Administrator's account and further stated that Resident #1 had demonstrated exit-seeking behaviors during her stay at the facility. Staff C indicated that it was generally known among staff that Resident #1 was at risk for elopement; however, this risk was not documented in the resident ' s record or health assessment. These findings were reviewed with the Administrator during the exit conference on , . The Administrator acknowledged the concerns and stated that corrective actions would be implemented to address the identified deficiencies. Class III	A 025		
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.	A 160		

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A 160	Continued From page 4 (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 [illegible]; 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 . (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.	A 160		

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A 160	Continued From page 5 (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 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,	A 160		

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A 160	Continued From page 6 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 record review and interviews, the facility failed to maintain documentation of incidents involving two of two sampled residents (Resident #1 and Resident #3). The findings included: On , , during an investigation related to Resident #1's elopement, the Administrator was asked to provide the facility ' s incident log. Review of the log showed that it was blank. The Administrator stated that he was not aware of any incidents that needed to be recorded. On , , , an unnamed source reported that Resident #1 eloped from the facility and was later found barefoot and . The resident was transported by law enforcement to a nearby hospital for treatment and subsequently returned to the facility. An interview with Resident #2 on , , at 11:20 a.m. revealed that he experienced multiple shortly after admission to the facility. He stated that he has not had any recent and believed the incidents occurred approximately six months prior. Review of Resident #2's records indicated he was admitted on , with diagnoses including , , , type II , , , and , . His health assessment (AHCA Form 1823), dated , , documented that he required	A 160		

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A 160	Continued From page 7 supervision for ambulation and assistance with all other activities of daily living. During a follow-up interview on , , at 11:20 a.m., the Administrator acknowledged that Resident #1 did elope from the facility and acknowledged their failure to record the incident in the incident log. The Administrator also admitted that Resident #3 was at times found on the floor but stated that he did not consider these incidents to be "true ." No additional information was provided by the Administrator during the exit conference on , . Class III	A 160		
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:	A 165		

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A 165	Continued From page 8 1. ; 2. or , damage; 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,	A 165		

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A 165	Continued From page 9 chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall 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 a review of the facility's incident policies (including adverse incident reporting), Resident #1's records, and staff interviews, it was determined that the facility failed to follow its own policy and regulatory requirements for reporting an adverse incident involving one of one sampled resident (Resident #1).	A 165		

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A 165	Continued From page 10 The findings included: The facility's incident policy states that all incidents involving residents, staff, or visitors must be reported and managed in accordance with facility procedures and regulatory requirements. An incident report dated , from an unnamed source documented that Resident #1 was found six blocks from the facility on , . The report indicated the resident was located by law enforcement, appeared , and had on her . However, review of the facility ' s incident log showed no record of this event, as the log was blank. Review of Resident #1's records on , , confirmed the resident was admitted on , . The health assessment (AHCA Form 1823), dated , documented diagnoses including ' s , , , , and . The assessment indicated the resident was not identified as an elopement risk but required assistance with ambulation. During an interview on , , at 10:30 a.m., the Administrator confirmed that Resident #1 eloped on , . The Administrator stated that he responded to the facility and assisted in searching for the resident, and law enforcement was contacted. The Administrator also acknowledged that an adverse incident report was not submitted to the Agency as required. These findings were reviewed with the	A 165		

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A 165	Continued From page 11 Administrator during the exit conference on , . . The Administrator acknowledged the deficiency and stated that corrective actions would be taken. Class III	A 165		