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
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(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 Complaint Survey CCR# 2012006769 An Assisted Living Facility complaint inspection survey was conducted on [redacted]. The Plaza at Pembroke Park had licensure deficiencies related to the allegations found at the time of the visit. Note: The survey was conducted in conjunction with the Change of Ownership, the initial Limited Nursing Services licensure survey and a revisit to the Extended Congregate Care monitoring visit. Please refer to the separate reports.	A 000		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care	A 025		

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
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(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 025	Continued From page 1	A 025		

surrogate, or case manager if the resident is discharged or moves out.
(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide appropriate supervision for residents as evidenced by the failure to provide consistent monitoring of residents in the secured memory care unit.

The findings include:

Review of the posted facility daily schedule for 8/20/ care unit, reveals 2 aides and 1 activity aide are assigned to the unit on the day shift, AM -3 PM. The staff scheduled to work that day were present on the unit during the survey. The daily census was noted to be 23 cognitively requiring monitoring.

On 8/20/ 10:45 AM, the surveyor observed 12 residents sitting around tables in the activity room. activity room at the most distant end of the unit. The surveyor observed a chaplain from a Hospice provider sitting in the room. surveyor inquired who he was and he stated he was waiting to speak with his client during her lunch meal. The surveyor did not see any facility staff in the room. surveyor

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
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(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 025	Continued From page 2 walked down the long hallway to the dining ... and observed the activity aide and one aide positioning residents at tables for lunch. The surveyor observed one aide and activity aide, pushing residents in their wheelchairs, one at a time, from the activity ... the dining ... lunch. While the staff were transporting the residents, down the long hallway, the remaining residents in both the activity ... the dining ... were left unattended. The transfer process continued until all residents on the unit had been brought to the dining ... The majority of residents living in the unit require staff assistance and guidance to move from location to location. And the residents require ... precautions due to ... and poor safety judgement. On ... at approximately 10:55 AM the surveyor observed a 2nd aide enter the unit. During an interview with the aide, she stated that the 2 aides take their breaks and meals separately, never together. She stated only one aide can go at a time, leaving one aide on the unit. On ... at the lunch meal starting at 11:15 AM, the surveyor observed 2 managers, along with the 2 aides and activity aide, assisting the residents with their meals. Two kitchen staff were observed providing drinks to the residents. At 12:30 PM the surveyor observed 9 residents sitting in the dining ... no supervision. All trays and dishes had been removed from the tables. Staff was observed down the hallway transporting residents to their ... and the activity ... Residents were overheard saying they needed to use the toilet. Residents were observed attempting to stand and move from the dining tables. Several residents were observed to	A 025		

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
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(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 025	Continued From page 3 have very unsteady gait, navigating down the long hallway to the activity . . . . . their . . . . . . At 12:40 PM the surveyor observed 9 residents sitting in the activity . . . . . by facility staff. The activity aide was observed at the other end of the hallway, getting juice for one of the residents. The other 2 aides were assisting other residents with ADL care. On . . . . . at approximately 12:40 PM during an interview with an aide, she stated that she spends a lot of time wheeling the residents back and forth from the activity . . . . . the dining . . . . . She stated that most days she will have the residents sit in the hallway after lunch, so she can better monitor them. Five residents were observed sitting in their wheelchairs in the hallway, half-way between the activity . . . . . the dining . . . . . . On . . . . . at approximately 11:55 AM during an interview with a Department of Children and Families counselor who was in the facility visiting a resident, she stated she visits the resident every 2 weeks. She stated that she has witnessed the residents sitting unattended waiting to be transported to and from the dining . . . . . She stated that there was not enough staff present on the unit during meal time, to appropriately monitor the residents in both locations. She stated her client was able to propel herself in her wheelchair to the dining . . . . . . On . . . . . at approximately 12:00 PM during an interview with the medication nurse, she stated that she comes to the memory care unit to administer medications only. She routinely spends most of her time on the facility first floor Assisted Living Unit.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(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 025	Continued From page 4 On [redacted] at approximately 2:00 PM during an interview with the Executive Director, she stated that the Memory Care unit is staffed with 2- 3 aides per shift plus the activity aide. She stated that an aide should be supervising the residents. The surveyor informed her of the observations during the lunch period, she stated that the residents should be monitored and not left alone. On [redacted] at approximately 2:45 PM during an interview with the Executive Director, she stated that the Memory Care unit is routinely staffed with 3 aides plus 1 activity aide but only on 5 of 7 days each week. The other two days, the unit only has 2 aides. She stated the facility had been attempting to hire additional, appropriately trained staff for the unit. Class III	A 025		
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911449	A. BUILDING _____ B. WING _____	08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 5 complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida ..... Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s ..... and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d),	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6	A 030		

F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical . . . . . shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from . . . . . and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7	A 030		

any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to comply with the Resident's Bill of Rights, to ensure residents live in a safe, clean living environment as evidenced by the facility failure to follow proper hand washing control practices during medication administration for 3 of 3 random sampled residents. The findings include: On at approximately 11:45 AM the Licensed Practical Nurse, (LPN) was observed dispensing prescribed medication for 3 residents on the Memory Care Unit. The LPN did not wash her hands or utilize hand sanitizer, before she started administering the medications, between administering medication to each resident or after she completed the medication administration. On at 12:05 PM during an interview	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911449	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA AT PEMBROKE PARK, LLC	3535 SW 52ND AVENUE PEMBROKE PARK, FL 33023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 with the LPN she stated that a bottle of hand sanitizer is missing, it usually was on top of the medication cart. She was observed looking for the bottle of hand sanitizer in the medication storage . She was unable to locate any hand sanitizer. On at 2:00 PM an opened bottle of hand sanitizer was provided to the surveyor. The expiration date on the bottle was noted to be . On at approximately 2:30 PM during an interview with the Executive Director, she reviewed the bottle of hand sanitizer and she confirmed the product had expired. She stated she would replace the bottle immediately. She stated the staff are in-serviced on control practices regularly. Class III	A 030		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
The Plaza At Pembroke Park, LLC
3535 SW 52nd Avenue
Pembroke Park, FL 33023

RE: CCR #2012006769

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2012 by a representative from this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2012** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

for Arlene Davis
Field Office Manager

AMD/ls
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924