

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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	A 000		
	An Assisted Living Facility Standard Biennial licensure survey was conducted on Hollywood Beach Retirement Home had licensure deficiencies at the time of the visit.			
	Note: Complaint Inspection #2012009440 was conducted in conjunction with the survey. Please refer to the separate report.			
A 007 SS=D	58A-5.0181(1) FAC Admissions - Criteria	A 007		
	Admission Procedures, Appropriateness of Placement and Continued Residency Criteria. (1) ADMISSION CRITERIA. An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license: (a) Be at least (b) Be free from signs and symptoms of any communicable _____ which is likely to be transmitted to other residents or staff; however, a person who has _____ may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule. (c) Be able to perform the activities of daily living, with supervision or assistance if necessary. (d) Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. (e) Be capable of taking his/her own medication with assistance from staff if necessary. 1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident 's or the resident ' s surrogate, guardian, or attorney-in-fact 's			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

1NGO11

If continuation sheet 1 of 29

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 007	Continued From page 1 written informed consent to provide such assistance as required under Section 429.256, F.S. 2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident. (f) Any special dietary needs can be met by the facility. (g) Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapters 490 or 491, F.S. (h) Not require licensed professional mental health treatment on a 24-hour a day basis. (i) Not be bedridden. (j) Not have any _____ or 4 pressure sores. A resident requiring care of a _____ pressure _____ may be admitted provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident's record; and 3. If the resident's condition fails to improve within 30 days, as documented by a licensed nurse or physician, the resident shall be discharged from the facility. (k) Not require any of the following nursing services: 1. Oral, _____ or _____ suctioning; 2. Assistance with tube feeding; 3. Monitoring of _____ gases; 4. Intermittent positive pressure breathing	A 007	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 007	Continued From page 2 or 5. Treatment of surgical _____ or wounds, unless the surgical _____ and the condition which caused it have been stabilized and a plan of care developed. (l) Not require 24-hour nursing supervision. (m) Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. (n) Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator shall base the decision on: 1. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule; 2. The facility's admission policy, and the services the facility is prepared to provide or arrange for to meet resident needs; and 3. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C. (o) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents met the criteria for continued residency for 1 of 13 sampled residents (Resident #3). The findings are: Resident #3 was observed on _____ at 12:37 P.M. to be verbally aggressive with another resident. The other resident was overheard to tell the resident "no fighting" in a loud tone of voice.	A 007	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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 007	Continued From page 3 Earlier in the day the resident had been observed walking throughout the facility in his underwear until re-directed by staff. The resident's record was reviewed. The resident was admitted to the facility on 01. The Health Assessment documented that the resident was diagnosed with Vascula and The Health Assessment documented that the resident was independent with ADLS, on a regular diet and required assistance with medications. The record also contained a note from a psychiatrist dated that documented "disrobing, crying, in kitchen. Diagnosis and Recommend higher level of care." There were no facility progress notes documenting a response to the recommendation. In addition, the resident was ordered and pm, and the facility did not have nurses to administer the medications. The administrator was interviewed on at 2:50 P.M. and no additional information was provided. Class III	A 007		
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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 4 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 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.	A 030	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 030	Continued From page 5 (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), 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.	A 030	(X5) COMPLETE DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 (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 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	A 030	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 030	Continued From page 7 case of a resident who has been adjudicated mentally _____, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency 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, record review and interview, the facility failed to ensure that residents were free from _____ for 1 of 13 sampled residents (Resident #1). The facility failed to ensure that the required telephone numbers for lodging a complaint against the facility was posted in full view in a common area accessible to all residents and failed to ensure that residents were treated with respect and dignity. The findings are: 1. On _____ at 10:00 A.M. resident #1's bed	A 030	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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)
A 030	Continued From page 8 was observed to be equipped with two half bed-side rails. Both half rails were positioned on the same side of the bed with no space in between just as a full side rail would be positioned. The administrator was interviewed on _____ at 12:30 P.M. and said the resident was not on hospice. She was not aware why both rails were on the same side of the bed. She provided an order for a side rail dated _____ of 2011, but was not aware that the order had to be renewed every 6 months. In addition, she was unable to locate the consent from the responsible party for the use of the side rail. 2. The tour of the facility conducted on _____ at 9:58 AM revealed a poster for the Long Term Ombudsman Council. An interview was conducted with the administrator on _____ at approximately 3:34 PM during which she stated she was sure the required postings were available. She however could not locate the postings. 3. The tour of the facility conducted on _____ at 9:58 AM revealed an activities calendar posted on the wall in the common _____. The calendar listed activities for each day but did not give a specific time that each activity was to take place. An interview was conducted with the administrator on _____ at approximately 3:48 PM. She stated she was unaware that the activities needed to be offered at specific times. 4. The surveyor heard a loud clanging noise from the _____ to the dining _____. observed the administrator ringing what appeared to be a Cow's Bell. Residents were notified that the lunch meal was ready by the ringing Cow's		A 030	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED																						
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019																								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		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		A 030																							
	bell. An interview was conducted with the administrator on _____ at approximately 1:45 PM during which she stated she was unaware the bell would pose an issue, that she needed to let the residents know that the meal was served and that they seemed to respond to the bell. Class III																									
A 079 SS=D	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: <table border="1"> <thead> <tr> <th>Number of Residents</th> <th>Staff Hours/Week</th> </tr> </thead> <tbody> <tr><td>0-5</td><td>168</td></tr> <tr><td>6-15</td><td>212</td></tr> <tr><td>16-25</td><td>253</td></tr> <tr><td>26-35</td><td>294</td></tr> <tr><td>36-45</td><td>335</td></tr> <tr><td>46-55</td><td>375</td></tr> <tr><td>56-65</td><td>416</td></tr> <tr><td>66-75</td><td>457</td></tr> <tr><td>76-85</td><td>498</td></tr> <tr><td>86-95</td><td>539</td></tr> </tbody> </table> For every 20 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.		Number of Residents	Staff Hours/Week	0-5	168	6-15	212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079	
Number of Residents	Staff Hours/Week																									
0-5	168																									
6-15	212																									
16-25	253																									
26-35	294																									
36-45	335																									
46-55	375																									
56-65	416																									
66-75	457																									
76-85	498																									
86-95	539																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 079	Continued From page 10 4. At least one staff member who is trained in First Aid and _____ as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility. 5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least _____ must be designated in writing to be in charge of the facility. 6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement. 7. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident's care.	A 079	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 079	Continued From page 11 (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff	A 079	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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)
A 079	Continued From page 12 hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility did not have an accurate staff schedule and failed to meet the minimum required staffing levels. The findings are: On _____, the staff schedule was reviewed and documented that staff member #1 was assigned to work the night shift and works from 6:00 P.M. until 6:00 A.M., 6 days a week. Staff member #1 was observed working in the facility on _____ at 10:15 A.M. and interviewed. She said that she works nights and is supposed to sleep at the facility during the day. The owner is listed as working from 9 A.M. until PM, but at 10:00 A.M. on the day of the survey, she had just arrived.		A 079	
A 084 SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements		A 084	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 084	Continued From page 13 pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and nasal dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the	A 084	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 084	Continued From page 14 resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; and g. Recognize the general signs of adverse reactions to medications and report such reactions. (c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that staff had the required 4 hour assistance with medication course for 1 of 3 sampled employees (Staff Member #1). The findings are: The staff records were reviewed. Staff member #1 only had documentation of the two hour course to provide assistance with medication, and no documentation of the required 4 hour course. The administrator was interviewed on _____ at 1:54 P.M. and was unable to locate the information. Class III	A 084	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED :
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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)	
A 090	Continued From page 15	A 090		
A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Orders	A 090		
	(11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding _____ within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding _____ within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C.			
	This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff received the required training for 3 of 3 sampled employees (Staff Member #1, #2 and #3).			
	The findings are:			
	The staff records were reviewed and none contained documentation of the _____ _____ one hour training. The administrator was interviewed on _____ at 1:54 P.M. and no information was provided.			
	Class III			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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)	
A 092	Continued From page 16	A 092		
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities	A 092		
	Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based upon observation and interview, it was determined that the facility failed to ensure that food service was provided to its residents in a safe and sanitary manner. The findings include: During the tour of the facility on _____ at approximately 11:40 AM, the surveyor observed the following concerns: 1. Freezer 1# located in the multi-use _____, was observed to have three bottles of unfrozen milk placed directly on top of several bags of unfrozen chicken quarters. An interview was conducted with the facility owner at 11:41 AM, she stated			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 092	Continued From page 17 she was unaware that the milk could not be stored on top of the chicken and that she would toss the milk out. However, the surveyor observed that the milk was placed in refrigerator #1 and was used for the lunch meal. 2. Refrigerator #1, located in the kitchen, was observed to have a thermometer in the refrigerator. The thermometer was observed to be at 60 degrees. An interview was conducted with the cook on _____ at approximately 11:53 AM during which she stated the temperature might have risen due to the refrigerator door being opened. The door was closed and the thermometer re-checked 10 minutes later and was observed to register the temperature as 60 degrees. An interview was conducted with the administrator on _____ at 12:05 PM during which she stated either the thermometer or the refrigerator was broken and a later determination would be made to determine which one. 3. The tour of the kitchen also revealed numerous pots and pans and appliances stored on the floor of the kitchen, several of the pots were found to be unwashed and was "soaking" on the floor of the kitchen. 4. Dishes and utensils were stored openly in the kitchen on top of the food prep area. The surveyor observed vegetables and cereals and other food items also unopened on top of the food prep area. A dirty ceiling fan was observed to be on and rotating in the kitchen. An interview was conducted with the facility owner on _____ at approximately 12:40 PM. She stated she was aware that there were no lower cabinets or drawers in the kitchen for the storage of silverware or pots and stated she would	A 092	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(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)
A 092	Continued From page 18 immediately purchase added kitchen storage equipment. 5. The surveyor observed several _____ cockroaches in the dishes on top of the food prep area. The dishes were stated to be "clean", i.e., they were washed and sanitized and ready for use in the service of meals. 6. The surveyor observed toilet paper that is kept on top of the food prep area along with the dishes and utensils and was distributed to the residents by the cook upon request from the residents. 7. Observation of the lunch meal on _____ at approximately 12:10 PM revealed the administrator serving soup and the cook passing and resting several plates of prepared food on the counter in the dining _____. The counter was observed to have a dirty standing fan rotating and blowing dirt unto the plates on the countertop. 8. The surveyor observed several staff members and residents going in and out of the kitchen during the lunch service. Staff and residents were observed to not have a hair net in place. The surveyor observed loose _____ hair on the countertop next to the food that was served for lunch, the owner of the facility then place a roll of paper towels on top of the _____ hair. The paper towels was then distributed to residents during the lunch food service. 9. Several plates used for food service of the lunch menu on _____ were observed to be chipped, broken and or burnt. 10. The surveyor observed lunch plated and placed on the table on _____ at		A 092	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 092	Continued From page 19 approximately 12:05 PM. The plates sat uncovered until all the plates were fixed, then residents were summoned for lunch. The surveyor observed a resident approach table #1 and stuck his fingers into the cups, glasses and plates on the table. There was no staff member around to monitor the tables after the plates were placed at each seat. 11. The surveyor observed a loud clanging noise from the _____ to the dining _____. _____ observed the administrator ringing what appeared to be a Cow's Bell. Residents were notified that the lunch meal was ready by the ringing Cow's bell. An interview was conducted with the administrator on _____ at approximately 1:45 PM during which she stated she was unaware the bell would pose an issue, that she needed to let the residents know that the meal was served and that they seemed to respond to the bell. This was not a homelike dining experience for the residents. 12. The surveyor observed _____ at approximately 12:50 PM that Refrigerator #2 located in the dining _____. The refrigerator was observed to have several packages of bread. The surveyor observed a platter of unwrapped, undated pastries that were dry and old in appearance in the refrigerator. The dates on the packages of breads, buns and rolls were _____. An interview was conducted with the owner of the facility at 12:43 PM during which she observed the dates on the breads/rolls and buns. She stated that it was impossible to control everything and that the breads would be tossed out.	A 092	

If continuation sheet 21 of 29

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 093	Continued From page 21 established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. 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 to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall 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 which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident's refusal to comply with a therapeutic diet and notification to the resident's health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident's responsible party refusing the diet is acceptable documentation of a resident's	A 093	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 093	Continued From page 22 preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall 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, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.	A 093	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 093	Continued From page 23 This Statute or Rule is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure that food was served at safe and palatable temperatures, and that the posted menu was followed. The findings include: An observation of the lunch menu was conducted on at 12:05 PM. Staff members were observed plating food and placing the plates on the tables by each chair. Interview was conducted with the facility administrator on at approximately 12:11 PM during which the surveyor inquired as to the amount of soup she plated. She wanted to know what difference it made as she gave the residents more than the required amount. She stated she was unaware she needed to measure the amount of soup served. She stated that the scoop she was using was about 4 ounces and she placed three scoops in each bowl for a total of 12 ounces. The posted menu was observed to have 6 ounces of soup. An interview was conducted with the facility owner on at 12:12 PM. She stated she did not know how much juice or milk was served to the residents. Observation was made of the lunch meal. The surveyor observed one resident being served items not listed on the menu and not documented as a substitute. An interview was conducted with the administrator on at 12:16 PM. She stated the resident did not like what was offered for lunch. Therefore, a plate was prepared for her, she was unsure of what portion sizes was provided for the resident.	A 093	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 24		A 093	
	The cook was observed to prepare plates of substituted items for those on the posted menu. An interview was conducted with the cook on _____ at approximately 12:25 PM. She stated that she is aware the sandwiches should be 3 ounces, but she does not have the ability to weigh the meat she is serving on the sandwiches. She stated she was unaware she needed to measure the potato salad that was served on the day of the inspection to ensure the resident received an adequate amount. The surveyor inquired of the temperature of the food she was serving. She stated there was no thermometer available. An interview was conducted with the facility owner and her mother. The facility owner was unaware that a thermometer was necessary for the kitchen. She stated that there was a thermometer in the kitchen but it was broken. She was corrected by her mother who advised her that the thermometer in the refrigerator could not be used to take the temperature of the food being served. Class III			
A 152 SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other		A 152	
	(3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must 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 shall be given the option of using their own			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 152	Continued From page 25 belongings as space permits. When the facility supplies the furnishings, each resident 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 a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, 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 _____ 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 shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide a safe, decent living environment that is free of hazards with all architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. The findings include:	A 152	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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)
A 152	Continued From page 26 A tour of the facility was conducted on _____ at approximately 9:30 AM and revealed the following: _____ Full bed rail observed on bed #1, curtains are extremely dirty. Ceiling fans are covered in thick layer of dust, exposed pipes in ceiling are also observed to have thick layers of dust in the ceiling. Two containers of medications belonging to unknown person(s) were found in the _____. The medications were Voltaren 1% gel and Pelond 0.1% eye drops. Ceiling in the rear of the _____ observed to be heavily stained. Bed #3 was observed collapsing to one side. The wall behind the bed was observed to be damaged. Bed #2 was observed to have two containers of medications belonging to resident for bed #3 at the bottom of the adjacent night stand. _____ Bed #1 comforter has numerous holes, the pillow was observed to be extremely filthy, the mattress is ripped and heavily stained. Bed #3, headboard and wall is heavily stained, furniture was observed to have a thick carpet of dust and the bed was observed to be hallway positioned in the closet. Exterior of _____ ceiling structure to be falling apart, exposed wood of underlying roof observed to be termite damaged and broken, wall is peeling and shows deterioration in several areas on both buildings, door jams and doors are in extremely poor conditions, windows are observed to be broken (6) and wall A/C units were observed to have severely damaged walls with dripping water which has eroded the plaster on the outside and damaged the walls on the inside of the resident's _____ and dustpans are strewn about the outside in the yard	A 152	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 27 and are filthy and water logged, peeling paint. Handrails are broken and missing anchoring pieces, shaking. Fascia board badly deteriorated around buildings, chairs on patio observed to be both broken :A/C vent dripping water onto floor, cobwebs evident all over tiles on floor cracked, musty odor in wall and baseboard extremely deteriorated. #: Floor filthy and debris covered, beds are dirty with residents in the beds, bathtub are filled with grime. Food strewn over floor and under beds extremely filthy. Food stains on furniture, lingering odor of smoke, cigarette bus on floor, ceiling heavily stained, walls are stained and extremely dirty with several holes observed next to the resident's beds. A/C vent heavy layer of dust, bathtub disgustingly filthy. :Peeling paint above door, curtains observed to be on broken rods, stand by bed #1 badly deteriorated, lamp missing shade. A/C unit in corner of the observed to have rotted wood in the window frame, bathtub was observed to have peeling paint and is extremely grimy, shower curtain is ripped and needs to be replaced. Common phone jack from wall, sofa covered by filthy, extremely dirty and bleached out blanket, bread on freezer dated walls have heavy water stains observed running down walls. Hole in ceiling over sofa. Floor was observed to be extremely filthy, accumulation of dirt and debris and water	A 152	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD BEACH RET. HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1722-26 MADISON STREET HOLLYWOOD, FL 33019	
(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 28 on medication cart, wall by door damaged, ceiling has rust on tiles. Kitchen - window observed to be missing cover for casing exposed concrete and dust, door frame also observed to be missing casing. 2 Busted chairs in dining , wall has large hole with broken pipe sticking out by hallway, curtain on rods that are concave, pile of clean linen found on chair in dining , floor tiles missing in kitchen, sink has no drain cover. Laundry area - Machine/dryer extremely rusted. Class III	A 152	



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Hollywood Beach Ret. Home
1722 - 26 Madison Street
Hollywood, FL 33019

Dear Administrator:

This letter reports the findings of a state licensure 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 Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

