STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911449	**05/11/2018**
NAME OF PROVIDER OR SUPPLIER **PLAZA OF HALLANDALE BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3535 SW 52ND AVENUE** **PEMBROKE PARK, FL 33023**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Complaint Survey CCR #2018002599 was conducted on through at Plaza of Hallandale Beach Assisted Living Facility, license #5120. The facility had a deficiency at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview, it was determined that the facility failed to provide care and services appropriate to meet the needs of a resident. This was evidenced by the failure to provide adequate supervision and oversight to a resident with a history of , and to implements steps and procedures to prevent future , for 1 of 3 sampled residents (Resident #1).

The findings included:

Record review of Resident #1's file revealed a summary visit from the doctor's office regarding dated for . Under the reason for visit it states , , and mild. Review of the progress notes for Resident #1 dated for , revealed that the resident had a slip and on the morning shift. The nurse was present and the resident was taken to the hospital and the family was notified. Review of the progress note entry for at 6:00 AM, documents that the resident went to the hospital for a second time due to a . Further review of an additional progress note entry dated for , documents that Resident #1 was found on the floor by the closet in a half sitting position at 11:10 PM the family was notified. Review of the progress note entry for at 6:15 AM and on at 6:30 AM revealed that Resident #1 sustained a on both days. Review of the progress note entry revealed no documentation of where the family was notified.

Review of Resident #1's Health Assessment (AHCA 1823 form) revealed a medical history and diagnosis of , , , , , , History of , chronic kidney , history of . Review of the section labeled physical and sensory limitations documents Gait , . Under the section labeled or behavioral status it states , memory and recognition with 's , and under the section labeled special precautions it states precaution. However, further record review revealed no evident of the system/steps implements by the facility to address this special precaution.

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Review of the incident logs at 11:15 AM from , to revealed that Resident #1 is documented once for a on at 11:10 PM by the closet with no apparent injuries noted. Further review of the logs/ incident reports revealed no documention for the other .

During an interview with the Administrator at 3:17 PM on regarding the system put in place to prevent Resident #1 from falling it was stated that she is unsure of what system is being put in place to prevent the residents . The Administrator advised the surveyor to speak with the Director of Nursing (DON) and that she should be able to give the surveyor an answer.

During an interview with the DON at 3:25 PM on , it was stated that the facility does not have a plan in place to prevent for Resident #1 because some days the resident has "good days and some days bad days". The DON further stated that the resident has been getting better with calling the staff when he needs something. During this time the DON was made aware of the resident's diagnosis by the surveyor, and given Resident #1's 1823 form to review.

During an additional interview with the DON on at 3:30 PM regarding the facility's established care plan for the resident it was stated that lately they have been attached to the residents 1823 form. Review of the form revealed no care plan attached to it or in the file. The DON was also unable to provide any documentation of a care plane. The DON during discussion regarding why incident reports were not completed for the other sustained by Resident #1, the DON was also unable to provide an explanation. The DON was also unable to provide any evidence of any steps/procedures implemented to prevent further of resident #1.

Class III