STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911449	**05/31/2018**
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 licensure complaint survey, CCR# 2018003499 and 2018004407, was conducted on at Plaza of Hallandale Beach, License # 5102. The facility had a deficiency at the time of the investigation.

Deficient practice identified at CCR # 2018003499 .

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, it was determined that the facility failed to complete an adverse incident report (1 day and 15 day report), for any incident in which law enforcement is involved, for 1 of 3 sampled Residents. (Specifically, Resident # 2).

The findings included:

A review of a progress note in the Resident's medical chart dated , reveals the Resident was observed banging on the refrigerator, yelling and screaming he could not sleep at 02:30 PM in the afternoon. Staff A, a Licensed Practical Nurse on duty at the time, noted that the Resident was demanding his sleeping medication. She stated he proceeded to drop himself to the floor. She called Law Enforcement and 911. The Resident was transported to the local , hospital. The note written by the Nurse indicated the facility Physician was not contacted. The note does not indicate whether the Resident was by Law Enforcement for being a threat to himself or others. The note does not indicate that an Adverse Incident Report was completed because Law Enforcement was contacted.

A review of the Nurses progress note dated stated Resident # 2 hit his in the face and broke his TV stand. The Nurse documented that she received a call from the Resident's mother called her and advised her that Resident # 2 had called her and stated he was going to commit . She called Law Enforcement and 911 and had the Resident . The notes fail to indicate the Nurse notified the facility Physician or Psychiatrist. The facility was not able to provide evidence of the or transfer to the hospital for this Resident.

On at 02:30 PM, an interview was conducted with the facility Administrator and the Wellness Director. They indicated that the Nurse was no longer employed at the facility. The Administrator stated

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the facility Physician should have been contacted in each event. She further stated that an Adverse Incident report should have been completed for the incidents because Law Enforcement was called. She stated that Staff A should have maintained a copy of the report. She acknowledged the findings and indicated the progress notes were incomplete.

Class III