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 _____	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA OF HALLANDALE BEACH	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 An unannounced Complaint survey, #2026008999, was conducted at Plaza of Hallandale Beach on . The facility had deficiencies at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify/or timely notify family or responsible party of an incident involving a Resident for 1 of 13 Resident sampled (Resident #1). The findings include: On the Administrator provided this surveyor with a Plaza of Hallandale Beach A.L.F. Accident/Incident/Illness Report form dated at 9:45 PM, which documented an incident involving Resident #1 and Staff H. A review of the form documented the employee involved was Staff H. It documented a staff	A 025		

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A 025	Continued From page 2	A 025		

member (unnamed) exited the nursing office after hearing yelling coming from the unit area. Upon arrival, resident was observed exhibiting aggressive behavior toward staff. Staff member was attempting to keep distance from resident. - Resolution: Removed resident from area and calmed him, he stated he was ok & wish to go to bed. Placed in bed by staff (copy obtained).

A review of the Staff Report completed by Staff H dated , documented the Resident #1 was involved in a verbal altercation with CNAs. I approached the area to assist to deescalate the situation. The resident appeared upset regarding concerns of assistance being provided to another resident. While attempting to redirect and calm the resident, the resident became physically aggressive towards her. The resident kicked her & struck her in the . She tried to keep a distance between herself and Resident #1. Staff came to intervene." (copy obtained).

A review of the Staff Report by Staff J documented she was doing her 2-hour check in the hall way by when she heard Staff H telling Resident #1 to go to bed. He was cursing Staff B and Staff C, the CNA because he said they will not help Resident #4. They tell him they helped her but he was still going on. He left the and came up to 107 where Staff H was and he got up and punch her in her . Staff H told him to stop - he punch her again then the nurse came and broke it up."

A review of the Resident 1's Health Assessment - AHCA Form1823 dated documented his diagnosis as: ( ), , aneurysm, , HLD (,), ,

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A 025	Continued From page 3 , (,). It further documented his Activities of Daily Living (ADLs) as Assistance with Bathing, , Grooming, Toileting, Transfer; Independent with Eating; and Total care with Ambulation. In an interview with a family of Resident #1 on at 10:27 AM, she stated Resident #1 was involved in an altercation of in which he incurred an injury to his left . She stated the Administrator called the Resident Power of Attorney (POS) on / 2026 and was apologizing for not calling her when the incident occurred. She stated that she informed the Administrator that the incident happened on Wednesday ( ), so why wasn't he contacted before then. In an interview with the Administrator on at 11:41 AM, she stated that when spoke with the Resident's nephew (POA on yesterday) he was upset that they did not send him out to the hospital and she explained that she was a new nurse, she didn't want to call him that late, so she called him on Monday, and she called him yesterday. She stated she apologized that the nurse did not call him earlier, but she was dealing with her father's medical emergency. She stated they dropped the ball on this one. Class III	A 025		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily	A 165		

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A 165	Continued From page 4 establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's	A 165		

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A 165	Continued From page 5 investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or	A 165		

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A 165	Continued From page 6 administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to report adverse incident report of an incident involving a Resident for 1 of 13 Resident sampled (Resident #1). The findings included: On at 10:20 AM, a request was made to the Administrator, (Staff A) to provide any documentation related to an incident involving Resident #1 that may have occurred on . The Administrator provided a binder to the surveyors containing the incident reports. A review of the binder revealed it did not contain documentation related to the incident. In an interview with Resident #1's family member on at 10:27 AM, she stated that Resident #1 was taken to the (local) hospital upon a request by the Resident's Case Manager. In addition, the family member stated local law enforcement was called and responded to the facility regarding the incident. In an interview with Staff A on at 10:32 AM, she stated that she knew of the incident that occurred on and provided the surveyors documents. A review of the Plaza of Hallandale Beach A.L.F. Accident/Incident/Illness report dated revealed an incident did occur on involving resident #1. Specifically, that resident #1	A 165		

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A 165	Continued From page 7 incurred an injury to his left , , as observed by this surveyor during the survey on . During the interview on at 10:45 with the Administrator, a request was made for the Adverse Incident Reports (AIRS) related to the incident. The Administrator stated that the incident was not reported to Agency for Health Care Administration (AHCA). No additional information was provided during the survey. Class III	A 165		