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
	AL11910357	A. BUILDING: _____ B. WING _____	R 08/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE INN	1613 SW 3RD ST BOYNTON BEACH, FL 33435

(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 Complaint (#2025004913 & 2025004565) revisit survey was conducted at Parkside Inn on . The facility had uncorrected deficiencies at the time of the survey.	{A 000}		
{A 180}	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, , , incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964. The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml. The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with 's	{A 180}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 180}	Continued From page 1 or related , and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain an approved Comprehensive Emergency Management Plan (CEMP), as required to ensure the safety of the 36 out of 36 residents of the facility. The findings include: On , at 11:45 AM, the Administrator of the facility was asked to provide evidence of their approved Comprehensive Emergency Management Plan (CEMP). She stated that the plan was not yet approved. The Administrator further explained that due to change in the county's emergency plan processing their plan submission was delayed. Review of the facility's previously approved CEMP showed it expired . The last resubmission of the emergency plan was on .	{A 180}		

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{A 180}	Continued From page 2 During the exit meeting, the Administrator did not provide any additional information. Class III	{A 180}		