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
	AL11932514	A. BUILDING: _____ B. WING _____	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKSHIRE	85 BULLDOG BLVD. MELBOURNE, FL 32901

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A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the use of a bed rail was included in the record for 1 of 6 sampled residents (9.) Findings: On at 10:30 AM, a side rail assistive device was seen on the right side of resident #9's bed. The resident said she needed it to get up in bed and to stand up. Review of resident #9's record revealed a history of essential tremors, mild , , and . She needed assistance with transferring. The record did not	A 034		

AHCA Form 3020-0001

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

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A 034	Continued From page 1 include the residents' use of the rail. On at 9:41 AM, the findings were discussed with the administrator. On at 11:40 AM, the administrator said the use of the rail was not in the resident's record. Class III	A 034		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	A 052		

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A 052	Continued From page 2 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

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A 052	Continued From page 3 (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's	A 052		

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A 052	Continued From page 4 health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure unlicensed caregivers use proper procedures when assisting	A 052		

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A 052	Continued From page 5 with self-administration of medications for 1 of 2 unlicensed caregivers sampled (D). Findings: On at 11:08am while speaking to resident #4 in the hallway, unlicensed caregiver D was observed handing resident #4 a cup with 3 tablets in it. Unlicensed caregiver D did not prepare the medication in front of the resident and did not explain what the medications were for. Improper medication procedure was confirmed by Unlicensed caregiver D. During an interview on at 2:55pm the Human Resource Director confirmed unlicensed caregiver D did not have a valid 6 hour in person assistance with self-administration of medications training. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A	A 054		

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A 054	Continued From page 6 medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the medication observation record (MOR) was properly updated for 2 of 6 sampled residents (9 & 6) Findings: Review of resident #9's 1823, dated , revealed the resident needed assistance with self-administration of medications. Reviews of the MORs revealed not all of them had any known ␣ the resident may have the name of the health care provider and the health care provider's telephone number. On at 9:41 AM, the findings were discussed with the administrator. On at 11:40 AM, the administrator said	A 054		

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A 054	Continued From page 7 she was unable to provide additional documentation. Review of resident #6's record revealed a facility admission on . A 1823 heath assessment indicated needs assistance with self-administration of medications. Review of resident #6's , Medication Observation Record (MORs) revealed holes for the following dates. On , , , and at 9 AM D3 Tab 25 mcg. On at 9 AM B-1 Tab 100 mg, Tab 50 mg, and Polyeth Glyc POW 3350. On at 7 AM, , Tab 40 mg. On at 3:40 PM, Nurse E stated after review of resident #6's MORs. Unlicensed caregiver D was the med tech that day. I'm sure resident #6 received her meds. Something must have happened because it's just the one page and the resident received her other 9 AM meds. On at 10:40 AM, Unlicensed caregiver D stated during a phone interview, yes, I worked on and do recall giving resident #6 her medications that day. I guess I forgot to update the MORs. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	A 054		

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A 055	Continued From page 8	A 055		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other	A 055		

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A 055	Continued From page 9 locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days	A 055		

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A 055	Continued From page 10 of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a medication cart was locked and medications were secured. Findings: On at 9:32 AM, an unlocked medication cart was seen in an unlocked conference room. Medications were seen inside the cart. On at 2:29 PM, licensed practical nurse (LPN) E entered the conference room then removed something from the top of the medication cart. As she turned to leave the room, she was asked about the cart being left unlocked. She replied "it's not supposed to be" then locked it. On at 3:15 PM, an unlocked medication cart was seen in the common area outside the dining room. Medications were seen inside. Two residents were seated nearby. Unlicensed caregiver H exited a closed room. When asked why she left the cart unlocked, she replied, "sorry, she just pulled me away" referring to someone in the room she exited. The facility's medication storage policy, dated	A 055		

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A 055	Continued From page 11 , indicated centrally stored medications will be always kept in a locked medication cart or in the medication room. Class III	A 055		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice	A 081		

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A 081	Continued From page 12 orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal	A 081		

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A 081	Continued From page 13	A 081		

care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , neglect, and , ... The facility must use its prevention policies and procedures when offering this training.
(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:
1. Resident behavior and needs.
2. Providing assistance with the activities of daily living.
(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.

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THE BROOKSHIRE	85 BULLDOG BLVD. MELBOURNE, FL 32901

(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 081	Continued From page 14 (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure 1 of 6 sampled staff (C) received a minimum of 1 hour in-service training within 30 days of employment that covered reporting adverse incidents and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, a minimum of 1 hour in-service training within 30 days of employment that covered recognizing and reporting resident , neglect, and , using the facility's prevention policies and procedures when offering this training, and in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment and failed to ensure 1 of 6 sampled staff (B) comprehended the training they received on the facility's resident , neglect, and , policy and on the facility's emergency procedures. Findings:	A 081		

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A 081	Continued From page 15 Review of caregiver B's personnel record revealed a hire date of . On at 12:56 PM, caregiver B was asked if she received training on the facility's policies on identifying and reporting and neglect. She replied, "not necessarily." She said the training she received was through an online course. When asked if she received training regarding the facility's emergency plan the caregiver said the training focused only on evacuation as it related to a fire. She did not receive training on the facility's generator. A certificate of training, dated , indicated caregiver B received 1-hour training on resident and 1-hour training on reporting adverse incidents and facility emergency procedures. On at 3:47 PM, the findings were discussed with the administrator who said no method was used by the facility to determine staff comprehension of the training. Review of caregiver C's record review revealed a hire date of . The 2 hr. pre-service orientation dated found did not reveal evidence of training on the facility's policies and procedures. There was no documented evidence for elopement response training, 1hr reporting major incidents, reporting adverse incidents, facility emergency procedures, incident reporting training, and 1 hr. resident rights, recognizing/reporting /neglect training by an approved trainer or Administrator.	A 081		

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A 081	Continued From page 16 On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	A 081		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment 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, including techniques for control, and ensure unlicensed staff have adequately	A 084		

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A 084	Continued From page 17 demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the 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 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and 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 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; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing;	A 084		

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A 084	Continued From page 18 k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (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 6 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 may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two	A 084		

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A 084	Continued From page 19 hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 2 of 6 staff who assist with self-administration of medications obtained a minimum 6-hour initial training and 2 hour continuing education annually. Findings: Review of unlicensed caregiver C's record revealed a hire date of . A 6-hour self-administration of medications completion date of . Further review revealed the 6-hour course was completed online. A 2-hour update annually was also completed on online not provided by a registered nurse or licensed pharmacist. A review of staff D's record revealed she was hired on . Her record did not contain documentation of completion of a valid 6-hour assistance with self-administration of medication training. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	A 084		
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service	A 085		

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A 085	Continued From page 20 (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to ensure the person responsible for food service/or supervision of food obtained 2 hours of continuing education annually (dietary manager). Findings: On at 11:05 AM, the Administrator stated the Dietary Manager does not have the training for food service. He's going next week. He was just promoted to dining. On at 1:20 PM, the Dietary Manager stated during the observation of the emergency food and water. I'm responsible for ordering the food. Review of the Dietary Manager's record revealed a hire date of . The record revealed a 1 hr. nutritional and safe food handling completion . Further review revealed a promotion on to Dietary Manager.	A 085		

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A 085	Continued From page 21 There was no documented evidence that a 2-hour food service designee training was completed by a certified food manager or licensed dietician. Class III	A 085		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the	A 056		

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A 056	Continued From page 22	A 056		

health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package,

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A 056	Continued From page 23 they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication are filled or refilled in a timely manner for 1 of 6 residents sampled (14). Findings: On at 12:05pm an interview with resident #14 was conducted. She complained she had been missing her medication ( ) for 6 days. She inquired with the nurse about the medication and was told the pharmacy had been called but they still do not have it. She confirmed the Administrator was aware. A review of resident #14's record revealed she was admitted on . Her record contained a Resident Health Assessment form dated . Her diagnoses included a Pubic , and , , . She requires assistance with self-administration of medication.	A 056		

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A 056	Continued From page 24 Review of the facility notes did not find documentation of resident #14's primary care provider being contacted regarding missing medication. On at 10:47am Review of resident #14's Medication Administration Record (MOR) with Licensed Practical Nurse (LPN) J found a physician's order for Anasrozole 1mg daily at 5pm. The initials on the MOR had been circled indicating resident #14 did not receive the medication on and 31st and , , 2, 3, 4, 5, 6, 7, and 8. Further review of the MOR found documentation indicating why resident #14 was not receiving her medications as ordered. On Nurse notified. On Awaiting nurse notified. On waiting. On waiting. On Nurse notified. There was no documentations for , , , , , , or . Interview with LPN J on at 11:15 am confirmed the medication was still not available. LPN J said she would call the pharmacy. On at 11:45am the Administrator confirmed there was no proper documentation for a reasonable effort to refill resident #14's missing medication. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment,	A 078		

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A 078	Continued From page 25 newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's	A 078		

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A 078	Continued From page 26 health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 6 sampled staff (B, C, administrator) submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable and failed to ensure 4 of 6 sampled staff (B, C, administrator, dietary manager) had evidence of a negative ( ) exam on an annual basis. Findings: Review of caregiver B's personnel record revealed a hire date of . The record did not contain a written statement from a health care provider documenting the caregiver did not have	A 078		

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A 078	Continued From page 27 any signs or symptoms of communicable and evidence of a negative exam on an annual basis. On at 1:17 PM, the human resource director said she did not know why they were not available. A review of the Administrator's record revealed she was hired on . There was no documentation of a one time communicable statement. Her record also did not contain documentation of an annual assessment. Review of caregiver C's record revealed a hire date of . There was no documented evidence of a one-time communicable statement obtained, and the only examination was conducted on . There was evidence of an annual obtained for 2025. Review of the Dietary Manager's record revealed a hire date of . There was no documented evidence that an annual examination was conducted for 2024. The last examination was conducted on along with a one-time communicable statement. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	A 078		

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A 090	Continued From page 28	A 090		
A 090 SS=D	59A-36.011(11) FAC Training - (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 . (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 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel review and interview, the facility failed to ensure 1 of 6 sample staff (B) comprehended the training they received on the facility's policies and failed to ensure 1 of 6 sample staff (C) received training on the facility's policies. Findings: Review of caregiver B's personnel record revealed a hire date of . On at 12:56 PM, caregiver B was asked if she received training on the facility's policies. She replied, "I think it was online." A certificate of training, dated , indicated caregiver B received 1-hour training on . On at 3:47 PM, the findings were	A 090		

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	AL11932514	A. BUILDING: _____ B. WING _____	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKSHIRE	85 BULLDOG BLVD. MELBOURNE, FL 32901

(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 090	Continued From page 29 discussed with the administrator who said no method was used by the facility to determine staff comprehension of the training. Review of caregiver C's record revealed a hire date on . The record did not contain documentation to indicate caregiver C received at least one hour of training in the facility's policy and procedures regarding . On at 4:00 PM, HR stated we used ALF Boss Trainings and not use the facility's policy and procedures. She does not have any other training. (photographic evidence obtained) Class III	A 090		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent	A 093		

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A 093	Continued From page 30 possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. 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 must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the	A 093		

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A 093	Continued From page 31 facility for 6 months. (e) Therapeutic diets must 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 that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must 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, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has . . . with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity.	A 093		

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A 093	Continued From page 32 The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on facility's record reviews and interviews, the facility failed to maintain 6 months of dated and signed menus by a licensed dietician including a substitution log. Findings: The Dietary Manager was asked to provide a copy of the licensed dietician credentials, 6 months of dated, signed menus with portion sizes, and the substitution logs. On at 1:20 PM, the Dietary Manager stated we don't have a licensed dietician. The menus are approved by the owner, and I receive an email with the new menus. I don't know anything about keeping the menus. I've only been in my role for a month or so. On at 2:26 PM, the Dietary Manager stated, I'm waiting for an email for the 6 month of menus from the owner or Sysco. The Administrator was informed that the 6-month menus, portion sizes, substitution log and dietician license requested on were not provided by the facility's Dietary Manager. On at 9:18 AM, the Administrator provided copies of the undated/signed menus which included the portion sizes and a blank	A 093		

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A 093	Continued From page 33 substitution log. Adding, I'm waiting to hear from corporate about the dietician. We don't have a dietician in the building. On at 12:02 PM, Kitchen staff F, stated the Dietary Manager started , in his role. We use a different vendor now and they provide the menus. I don't believe they have a dietician. The old company came in and threw out the menus. I'll see if I can find an email when I use to receive them. The regulations, the facility failed to maintain 6 months of dated and signed menus approved by a dietician, a substitution log, and evidence the facility utilized a registered, license dietician for the menus posted as required. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	A 093		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.	A 161		

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A 161	Continued From page 34 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule	A 161		

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A 161	Continued From page 35 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure the record for 1 of 7 sampled staff contained a job description (Dietary Manager). Findings: On at 11:05 AM, the Administrator stated the Dietary Manager was just hired a few weeks ago. Review of the facility's Background Clearinghouse Roster revealed a hire date of . On at 11:05 AM, the Administrator stated that is correct after revealing the hire date. She added, he was hired in maintenance and promoted to dining a few weeks ago based on his prior experience. Review of the Dietary Manager's record revealed a hire date of . Further review revealed a job description of maintenance. There was documented evidence a new job description as the dietary manager was found. The Human Resources (HR) representative was asked to provide a copy of the Dietary Manager time sheet to determine the date of the promotion. On at 2:50 PM, HR stated, I'm not sure of the date or if the timesheet reveals his new title. However, I would have been required to submit documentation to payroll to make the	A 161		

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A 161	Continued From page 36 change in the system. On at 4:00 PM, HR provided a document titled Employee Master Form signed by the Administrator on , effective date from maintenance to dietary manager. The facility failed to update the personnel record by including the new job description for Dietary Manager. (photographic evidence obtained) Class III	A 161		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C.	A 162		

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A 162	Continued From page 37 (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌄ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.	A 162		

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A 162	Continued From page 38 (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, ... , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a	A 162		

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A 162	Continued From page 39 resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 6 sampled residents' ⌄ was recorded on admission (9) and failed to ensure 1 of 6 sampled residents (6) had their ⌄ recorded semi-annually. Findings: Review of resident #9's record revealed a facility admission date of . An admission ⌄ was not documented on the admission 1823 or anywhere else in the record. On at 2:25 PM, the findings were discussed with the director of nursing. On at 9:41 AM, the findings were discussed with the administrator. On at 11:40 AM, the administrator said a ⌄ was not available. Review of resident #6's record revealed a facility admission on . A 1823 heath assessment indicated needing assistance with ADLs.	A 162		

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A 162	Continued From page 40 The administrator was asked to provide the ␣ log for review. On at 3:45 PM, the Administrator stated the facility does not have ␣ for resident #6. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. Class III	A 162		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , , ␣ , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2	AE210		

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AE210	Continued From page 41 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (C) obtained 2 hours of training within 6 months of hire for Extended Congregate Care (ECC). The facility failed to ensure the Administrator had 4 hours of initial ECC training within 3 months of hire and 4 hours of continuous education every 2 years. Findings: Review of caregiver C's record revealed a hire date on . There was no documented evidence of 2hr training in ECC was completed. The HR representative was asked to provide additional training for caregiver C. A review of the Administrators' record revealed she was hired on . Her record did not contain documentation of 4 hours of initial ECC training within 3 months of hire or 4 hours of continuous education every 2 years. On at 4:00 PM, HR confirmed the findings, stating if it's not in her record she does not have it. Class III	AE210		

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ZZ000	Continued From page 42	ZZ000		
ZZ000	Initial Comments A survey for relicensure, complaint #2025009815, ECC and LNS monitoring, and a generator monitoring were conducted at The Brookshire Assisted Living Facility on and . There were deficiencies identified at the time of the survey.	ZZ000		
ZZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as	ZZ821		

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	AL11932514	A. BUILDING: _____ B. WING _____	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKSHIRE	85 BULLDOG BLVD. MELBOURNE, FL 32901

(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
ZZ821	Continued From page 43 required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On	ZZ821		

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ZZ821	Continued From page 44 Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory	ZZ821		

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ZZ821	Continued From page 45 Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after a resident experienced a with injuries that resulted in a transfer to a hospital for 3 of 6 sampled residents (1, 9, 14.) Findings: Review of resident #9's record revealed a facility admission date of . The resident's medical history included essential tremors, , , and mild , . She had in both , and used a wheelchair. She needed supervision with ambulation, , grooming,	ZZ821		

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ZZ821	Continued From page 46 toileting and assistance with bathing and transferring. Her admission 1823, dated , had an order for home health physical ( ) and occupational therapies ( ) as needed. On she and sustained a on her , . She complained of , in her , 911 was called. She was taken to a hospital. She returned the same day with on her lower , . She also sustained a . . . 1 . . A hospital discharge instructions indicated she had a single superficial to the lower , . Acute , associated with a , of 1. on the same level by tripping. A review of resident #1 record revealed she was admitted on . Her diagnoses included , , and , , and gait abnormality. On at 12:45pm resident#1 was observed on the floor. She complained of left , and felt , as she hit her on the wall. 911 transported to the hospital. On there was no time documented. Resident #1 was observed on the floor in the bathroom. She complained of , in , lower extremity, and , . 911 transported to the hospital. On at 6:30pm Resident #1 was observed on the floor. She complained about left and left heel , . Transported to the hospital. A review of resident #14 record revealed she was admitted on . Admitted . Her	ZZ821		

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ZZ821	Continued From page 47 diagnoses included pubic , and . On at 6pm resident #14 was observed sitting on the side of her bed on the floor. Superficial on the left side of . 911 transported to the hospital. On at 11:07am the Administrator confirmed there was no adverse incident report submitted when resident #1 and #14 were transferred to the hospital after with injuries. Unclassified	ZZ821		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with	ZZ875		

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ZZ875	Continued From page 48 ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care	ZZ875		

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ZZ875	Continued From page 49	ZZ875		

home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through

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ZZ875	Continued From page 50 on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until	ZZ875		

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ZZ875	Continued From page 51 the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure 2 of 6 sampled staff (B, C) completed a 1-hour training program on and related forms of (ADRD) provided by the Department of Elderly Affairs within 30 days after beginning employment and an additional 3 hours of training that included behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues from an approved trainer within 3 months after beginning employment and failed to ensure 1 of 6 sampled staff (B) completed an additional 4 hours of -specific training from an approved trainer within 6 months after beginning employment. Findings: Review of caregiver B's personnel record revealed a hire date of . The record did not contain documentation of a 1-hour training program on ADRD provided by the Department of Elderly Affairs, an additional 3 hours and 4 hours of training from an approved trainer. On at 1:30 PM, review of the facility's website revealed the facility advertised memory care. On at 1:17 PM, the findings were discussed with the human resource director.	ZZ875		

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ZZ875	Continued From page 52 On at 3:50 PM, the human resource director said there was no additional documentation. Review of caregiver C's record revealed a hire date of . The record revealed a 1 hr. Department of Elder Affairs (DOEA) completed on and 3 hr. and Initial Training. Further reviewed revealed the trainer was not approved by DOEA. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	ZZ875		
A 000	Initial Comments A survey for re-licensure, complaint #2025009851, ECC and LNS monitoring, and a generator monitoring were conducted at The Brookshire Assisted Living Facility on and . There were deficiencies identified at the time of the survey.	A 000		
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made	A 004		

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A 004	Continued From page 53	A 004		

without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C.
(3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C.
(4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter.
(5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result

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A 004	Continued From page 54 in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to obtain prior approval from the field office when its secured memory care unit was closed resulting in the discharge of 6 of 6 sampled residents (16, 17, 18, 19, 20, 21.) Findings: Review of the facility's licensure application, dated , revealed the facility offered memory care. During a tour of the facility on at 10:15 AM, no resident living areas were found to be secured. On at 1:30 PM, the administrator said the facility no longer used the second floor as a secure memory care unit. She said the residents who lived there were discharged. She did not obtain prior approval from the Agency field office because she believed prior approval was only required if renovations were done. Review of the facility's website revealed the facility advertised memory care. Review of the discharge log revealed the following residents were discharged because of closure of the memory care unit:	A 004		

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A	Continued From page 55 #16 and #17 on #18 on #19 and #20 on #21 on Class III	A 004		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is	A 008		

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A 008	Continued From page 56 performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident	A 008		

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	AL11932514	A. BUILDING: _____ B. WING _____	09/09/2025

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A 008	Continued From page 57 which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be	A 008		

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A 008	Continued From page 58 transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30	A 008		

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A 008	Continued From page 59 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or , (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a health assessment form (1823) was complete and accurately reflected the presence of a , for 1 of 6 sampled residents (9.)	A 008		

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A 008	Continued From page 60 Findings: Review of resident #9's record revealed a facility admission date of . Review of 1823, dated , revealed the residents' and the examiner's address were not documented. In addition, the form indicated the resident did not have a . There was no documentation to indicate the facility contacted a health care provider to obtain the missing information. A facility move-in nursing evaluation, dated , revealed the presence of two open areas on the and one on the left heel. On a health care provider ordered a consultation with a doctor. On a health care provider ordered a doctor to evaluate and treat on and left heel. A provider's note, dated , indicated the left heel was . An note indicated the was acquired on . On at 1:22 PM, observations of the resident's skin revealed a on the left heel that measured approximately 3 centimeters (cm) x 3 cm. The bed was 100% white, moist . The skin on the was intact. On at 10:30 AM, the administrator said there was no other 1823. Class III	A 008		

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A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for	A 010		

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A 010	Continued From page 62 nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.	A 010		

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A 010	Continued From page 63 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 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 health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	A 010		

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A 010	Continued From page 64 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility retained a resident who had [redacted] and who no longer met the minimum criteria for continued residency for 1 of 6 sampled residents (9) and failed to ensure 1 of	A 010		

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A 010	Continued From page 65 1 sampled resident (6) who received hospice services had an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility. Findings: Review of resident #9's record revealed a facility admission date of . Review of 1823, dated , revealed the resident did not have a . A facility move-in nursing evaluation, dated , revealed the presence of a left heel . On a health care provider ordered a consultation with a doctor. On a health care provider ordered a doctor to evaluate and treat , on left heel. A provider's note, dated , indicated the left heel was , . On at 1:22 PM, observations of the resident's skin revealed a , on the left heel that measured approximately 3 centimeters (cm) x 3 cm. The bed was 100% white, moist . The administrator was present. On at 9:41 AM, the administrator confirmed she saw the on and it looked the same as it did on . She last read the documentation a couple of weeks ago. She did not know the provider described the as . No steps were	A 010		

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A 010	Continued From page 66 taken by the facility to transfer resident #9 to a higher level of care because they tried to heal the . Review of resident #6's record revealed a facility admission on . A 1823 heath assessment indicated a medical history of Sjogren , , , , and has Vistas Hospice nursing services. Further review revealed no documented evidence of resident #6's initial interdisciplinary care plan (IDCP) for her admission to hospice. On at 2:33 PM, the Administrator was asked to provide resident #6's initial IDCP for review. On at 3:45 PM, the Administrator provided resident #6's hospice plan of care dated , stating this is what hospice provided. On at 5:00 PM, the Administrator and Director of Nursing confirmed the findings. (photographic evidence obtained) Class III	A 010		
A 025 SS=G	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	A 025		

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A 025	Continued From page 67 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 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,	A 025		

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A 025	Continued From page 68 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 observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for with injuries for 3 of 6 sampled residents (1, 9, 14) and failed to document in the record when 2 of 6 sampled residents were sent to a hospital (9, 14.) Findings: The facility's prevention program, dated , indicated in part that a risk assessment would be conducted upon admission to determine the resident's level of risk. The facility will identify the resident's risk and initiate interventions in accordance with their level of risk. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's service plan. When occurs the service plan will be reviewed and updated as indicated. Review of resident #9's record revealed a facility admission date of . The resident's medical history included essential tremors, , , and mild , . She had in both , and used a wheelchair. She needed	A 025		

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A 025	Continued From page 69 supervision with ambulation, , grooming, toileting and assistance with bathing and transferring. Her admission 1823, dated , had an order for home health physical ( ) and occupational therapies ( ) as needed. On she and sustained a on the top of her right . On she and sustained a on her right and on the left one. On she . On she and sustained a on her right . On she and sustained a on her , . She complained of , in her . 911 was called. She was taken to a hospital. She returned the same day with on her lower , . She also sustained a 1 . A hospital discharge instructions indicated she had a single superficial to the lower , . Acute associated with a , of 1. on the same level by tripping. On she . 2-hour checks were initiated. On she . The record contained a hospital transport request dated . There was no documentation explaining the hospital visit. On she twice. The second time was in the dining room when she hit her . She refused to be transported to a hospital.	A 025		

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A 025	Continued From page 70 On she . On she possibly from slipping on heel . She was instructed to call for assistance before transferring. On she and sustained a behind her left . On at 10:30 AM, the administrator said the resident never received and . On at 11:40 AM, the administrator said a service plan was not written. She said there was no documentation to explain the hospital visit, and she did not know why the resident was sent there. On at 3:15 PM, unlicensed caregiver H said interventions included making sure the resident's side rails were up. On at 3:25 PM, LPN J said interventions included checking on the resident every two hours, ensuring the bed was in the lowest position, instructing the resident to call for help, ensure the room was free of clutter, and that the resident wore proper footwear. The nurse said the resident did not usually call before transferring herself. On at 3:36 PM, caregiver I said preventions included checking on the resident at the start of his shift and providing her with bedtime assistance. He said sometimes she did not want help from staff. On at 3:47 PM, the administrator said there were no interventions for this resident.	A 025		

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	AL11932514	A. BUILDING: _____ B. WING _____	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 025	Continued From page 71 The staff told her to call for help. She has increased when she had a . On at 4:45 PM, the administrator said a risk assessment was never conducted. A review of resident #1 record revealed she was admitted on . Her record contained a resident Health assessment form (1823) dated . Her diagnoses inclided , , , and , , and gait abnotmality. She was independent with ambulation, , eating, grooming, and toileting. She required supervision with bathing and transfer. A review of resident #1's facility notes found documentation of 8 since . On at 10:20am resident observed on the floor. Stated she did not lock breaks on wheelchair. denied , or discomfort. On at 1pm found resident on the bathroom floor after unwitnessed . Resident said she while trying to go to the bathroom. On at 1pm resident observed with large amt of feces , bed, , and . Also noted on the floor. On No time documented. Observed on the floor in the bathroom. Complained of , in , lower exremity, and , . 911 transfer to hospital. On at 12:45pm resident observed on the floor. Trying to transfer from walker to wheelchair after using the bathroom. Complained of left , . She felt , after as she hit her on the wall. 911 transfer to hospital. On Resident observed on the floor in	A 025		

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A 025	Continued From page 72 front of her bathroom. Denies , . No apparent injury. Nurse observed wheelchair does not lock properly. On at 6:30pm Resident observed on the floor. Stated she was trying to get into the bathroom. Left and left heel , . Transported to the hospital. On at 6:15pm resident had an unwitnessed . Coming out from using the bathroom. On at 1pm an interview with resident #1 was conducted. She confirmed she had multiple . She complained the bars in the bathroom were for left handed people. She has left sided and is having difficulty. She had an over toilet chair with a right side assist handle but it gets moved when her roommate uses the restroom. Sometimes it does not get put . She confirmed the facility staff were aware as well as the , who is working with her. A review of resident #14's record revealed she was admitted on . Her record contained a 1823 form dated . Her diagnoses included a Pubic , and , , . She required supervision with ambulation. A review of the facility notes found On No time noted. Resident observed sitting on the floor in shower. No apparent injury. On at 6pm Roommate notified nurse that resident in her room. Observed sitting on the side of her bed on floor. Resident stated she hit her . Superficial . left side of . 911 to hospital.	A 025		

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A 025	Continued From page 73 On at 10:30pm Returned from ED. Staples in place to left side of . On no time noted. Resident found sitting on the floor in front of toilet. No apparent injury. On at 11:25am resident arrived to the facility. On Resident currently at the hospital with d/c plans to Sea Pines rehab. There was no facility documentation explaining why resident #1 was transferred to the hospital. On no time noted. Resident found on the side of her bed. No apparent injury. On no time noted. Resident observed on the floor beside bed. Denies injury. On No time noted. Resident slid off her bed. No injuries On at 11:07am the Administrator confirmed there was no adverse incident report submitted when resident #1 and #14 were transferred to the hospital after with injuries. On at 11:45am the Administrator confirmed no formal plan of care for resident #1 or #14 was completed. No documentation of time or date resident #14 went to the hospital. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or	A 032		

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A 032	Continued From page 74 with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:	A 032		

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A 032	Continued From page 75 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 6 employees participated in 2 elopement drills annually (A, Administrator). Findings: A review of the Administrators' record revealed she was hired on . Her record did not contain documentation of participation in 2 elopement drills in 2024 or 2025. A review of caregiver A's record revealed she was hired on . Her record did not contain documentation of participation in any elopement drills in 2024 or 2025. On at 4:20pm the Administrator confirmed the finding. Class III	A 032		

Agency for Health Care Administration

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