

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910541</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/10/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUMMER'S LANDING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>615 FLORIDA AVENUE<br/>LYNN HAVEN, FL 32444</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| A 000                                                       | Initial Comments<br><br>An unannounced complaint survey was conducted at Summer's Landing, an assisted living facility located in Lynn Haven, FL, on _____ to review complaint #2025016553. Deficient practice was identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A 000                                                                                       |                                                                                                                          |                                                                    |
| A 025<br>SS=D                                               | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____, _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: | A 025                                                                                       |                                                                                                                          |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

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| A 025                                                       | <p>Continued From page 1</p> <p>(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.</p> <p>(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.</p> <p>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.</p> <p>(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.</p> <p>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff update resident records of any significant changes or illness that resulted in medical attention and hospitalization for 1 of 3 sampled residents reviewed for hospitalization. (Resident #4)</p> <p>The findings include:</p> <p>A review of Resident #4's medical record revealed he was sent to the hospital emergency room on . . . . The record contained no information of why the resident was sent to the</p> | A 025                                                                                       |                                                                                                                          |  |                                                                    |

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| A 025                                                       | <p>Continued From page 2</p> <p>hospital on .</p> <p>An interview was conducted with the Director of Resident Services (DORS) on at 1:25 PM. She stated the facility had no other documentation in the resident's record to explain why he went to the hospital on other than the medication record indicating "leave" on due to transfer to a hospital emergency room and the sheet indicating that the resident moved out on due to a decline in health.</p> <p>An interview was conducted with the Administrator on at 2:03 PM. The Administrator stated the staff should have documented why the resident went to the hospital and confirmed it was not documented.</p> <p>Class III</p> | A 025                                                                                       |                                                                                                                          |                                                                    |