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
	AL11969794	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRABELLE	7400 SW 88TH ST MIAMI, FL 33156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (2025016837) was conducted at Mirabelle from to . The provider had deficiencies identified at the time of the survey.	A 000		
A 010 SS=G	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	A 010		

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A 010	Continued From page 1 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 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.	A 010		

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A 010	Continued From page 2 (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. 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	A 010		

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A 010	Continued From page 3 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 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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the continued appropriateness of residence of one out of 14 sampled residents (5) The Resident had a change in condition that required 24-hour care and sustained multiple resulting in injuries. Findings included: A review of the facility's incident log showed that Resident 5 on , on , on and on . Interviewed on at 7:39 AM Staff I identified Resident 5 as having multiple at the facility. A review of Resident 5's progress notes showed that on the Resident was found on the floor unable to explain what happened and he was transported to the hospital via 911. Further review of Resident 5's progress notes showed that on he was found by staff on the floor outside of his bedroom unable to explain how he and he was taken to his private physician by his son. Further review of Resident 5's progress notes showed that on the Resident was found on the floor in his apartment complaining of , in the area, he was shivering, a clot was observed in his , and he was transferred to the hospital via 911. Interviewed on at 11:00 AM Staff M stated, "I was on duty when [Resident 5's] had the four during the daytime, not at nighttime. On	A 010		

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A 010	Continued From page 5 he tried to stand up from the recliner, did not have the strength and slid to the floor. After that he called me and I immediately called the nurse to come and check him, the nurse found that he had a clot that was obstructing the output. I was making my rounds around 10:00 AM and found him on the floor, he said that he went to the bathroom to poop and getting out of the bathroom he because he lost the strength, I told him to call me anytime he needs help, he said that he did not press the pendant because he could not do it. He was . We use [Resident care software program] and it was documented that he was and ; For his other two he was weak, he was with his sheet on the floor; apparently, he tried to get out of bed and slid to the floor, he had no injuries. When he pressed the pendant, he had already . He had no private aide. We started to check on him more frequently and started going to his room every half an hour." A review of Resident 5's health assessment dated showed diagnoses of , retention, acute , , , , , , exacerbation and ; had and , precautions and required assistance with all activities of daily living (ADL) of ambulation, bathing, , self-care, toileting, and transferring. A review of an email correspondence dated revealed that the Director of Resident Care communicated to Resident 5's daughter that the Resident required 24 hours care due to a change of his condition and urged her to contract the services of 24- hour private duty aide.	A 010		

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A 010	Continued From page 6 A review of an email correspondence dated revealed Resident 5's Daughter responded to the Director of Care acknowledging her father required a higher level of care and she was trying to obtain 24/7 care for the Resident. Interviewed on at 6:00 AM Resident 5's Private Duty Aide stated the Resident had several times and he had private duty aide service 24 hours a day. Class II	A 010		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards.	A 025		

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A 025	Continued From page 7 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, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain adequate supervision for 8 out of 13 sampled residents (Residents # 1, 2, 3, 4, 5, 6, 7 and 8) that had precautions and suffered at the facility, Residents # 1, 2 and 3 suffered . . .	A 025		

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A 025	Continued From page 8 Findings included: A review of facility records revealed that there were 34 reported at the facility during a 60-day period resulting in several injuries including . 1- A review of facility records showed that Resident #1 sustained 3 at the facility, on at approximately 8 PM she suffered a displaced , and , . On and on Resident #1 was found on the floor and sustained a hematoma on the right frontal area and on the left side of the respectively. A review of Resident #1's record showed that the health assessment completed on had her diagnosed with , , , and lymphoma, she was on precautions and required assistance with all activities of daily living. 2- A review of facility records showed that Resident #2 sustained a after she was found on the floor on at approximately 11 PM. A review of Resident # 2's record showed that the admission sheet had her diagnosed with folate deficiency, , , type 2 , hypercholesteremia, , , , , , , , status post . The health assessment completed on stated that she was on precautions, required supervision with eating and required assistance with ambulation, bathing, , grooming, toileting and transferring.	A 025		

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A 025	Continued From page 9 3- A review of facility records showed that Resident # 3 sustained a left following a at the facility on at approximately 5:30 PM. A review of Resident # 3's records showed that he suffered 4 at the facility, on he sustained on his and , requiring stitches after he was found on the floor. The Resident was also found on the floor on when he sustained scrapes to his right , on at 2:20 PM and on at 9 PM he attempting to transfer from his wheelchair and sustained skin breakage. 4- A review of facility records showed that Resident # 4 suffered 4 at the facility, on sustained on his and , requiring stitches after he was found on the floor. The Resident was also found on the floor on at 9:50 PM when he sustained scrapes to his right , on at 2:20 PM and on at 9 PM when he attempting to transfer from his wheelchair and sustained skin breakage. A review of Resident # 4's record showed that the health assessment completed on had him diagnosed with with left , , , status post Rhinovirus, , , , , , , ; he was on precautions and was independent with eating and required assistance with the rest of the activities of daily living. 5- A review of facility records showed that Resident# 5 experienced four at the facility. On at approximately 5:29 AM staff	A 025		

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A 025	Continued From page 10	A 025		

found him on the floor with no apparent injuries and was sent to the hospital for further evaluation. On at approximately 2:30 PM staff found him on the floor after he attempting to transfer and was referred to the hospital complaining of , in the area and a clot was observed in his . On at approximately 8:00 AM he was found in a supine position outside his bedroom and was unable to explain how he ended up on the floor. On at approximately 10:20 AM he was found on the floor next to his bed, he could not remember how he .

A review of Resident # 5's record showed that the health assessment completed on had him diagnosed with acute on , retention, acute , , , , , exacerbation, , ; he is on and precautions, required assistance with all activities of daily living.

6- A review of facility records showed that Resident# 6 had 2 , on at approximately 2:24 PM suffered a in the activities area when she attempted to stand up unassisted and slipped forward, striking her on a chair, she was transported by to the hospital. On at approximately 2:17 PM the resident in the shower in the morning, the [Resident Assistant] had her sitting on the shower chair when the had turned to grab an item, the chair was also on the floor, she had no injuries.

A review of Resident # 6's record showed that the health assessment completed on had her diagnosed with , , , , , , history of right

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A 025	Continued From page 11 , . She was on precautions and required assistance with all activities of daily living. 7- A review of facility records showed that Resident # 7 suffered 2 , on at approximately 9:31 PM and stated that she to her left side, with no injuries. On at approximately 9:57 PM she called her pendant and was found on the floor and sustained a to the left , stating that she had lost her balance. A review of Resident # 7's record showed that health assessment completed on had her diagnosed with severe , with , features, , , , , hearing loss. History of , history of left history of valve repair, nodules, , , recurrent . The resident was on precautions and needed assistance with bathing and eating, supervision with ambulation, , and self-care and was independent with toileting and transferring. 8- A review of facility records showed that Resident # 8 suffered 2 , on at approximately 4:21 AM was found on the floor after feeling , and attempting to sit on the couch and to the floor, he was transferred to the hospital for further evaluation. On at approximately 8:24 PM the resident suffered a hitting his , he was sent to the hospital. A review of Resident # 8's record showed that the non-dated health assessment had him diagnosed with shortness of , on precautions and requiring assistance with all activities of daily living.	A 025		

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A 025	Continued From page 12 On at 6:51 AM Staff D [Licensed Practical Nurse] stated that the residents constantly, mainly in the morning, when they try to get to the bathroom or they get up in the middle of the night and do not press the pendant or they press it and the staff takes 3 or 4 minutes to get to the resident and they do not want to wait. Most of the time they hit their heads. On at 7:11 AM Staff G, [Resident Assistant] stated that if there is a missing staff they divide one floor, that she was not trained by the facility on what to do when a resident , she was explained by another . On at 7:22 AM Staff H, ( ) stated that she was trained by another staff what to do in case of . On at 7:27 AM Staff K ( ) stated that she was trained by a more experienced who told her what to do in . On at 7:39 AM Staff I, ( ) stated that there have been many changes, some for better, some for worse, that if a staff calls sick, they have to work more, sometimes they call other staff to come to work and they cannot get anyone or they just don't call. Stated that last year she worked 4 floors in one day, that there have always been . There were residents with more , Resident# 5, 8, 3, 1 and 4, they have declined. On at 10:30 AM Staff M (Med Tech) stated that if someone calls sick, they have to work with more residents. On at 10:36 AM Staff J stated that there were a lot of residents on her floor and another	A 025		

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A 025	Continued From page 13 staff was needed. On at 10:40 AM Resident # 8 stated that he has had a few but had no injuries, that he called the staff and sometimes it would take up to half an hour for them to come to their room because they are busy with other residents. Resident # 8 shares the room with his wife, a review of the call pendant revealed that on it took staff 43 min 8s to answer the call bell to his room. On it took 33 min 12 s, on and it took 26 min, on took 28 min, on 37 min, on 36 min, 33 27 min and on it took 2 hours and 48 min. A review of the call pendant answer log for Resident # 2 revealed that it took 21 min for the call to be answered. A review of the call pendant answer log for Resident # 5 revealed that on it took 47 min to answer, same day another call took 21 min to be answered, on 54 min, on 50 min. Class II	A 025		
A 079 SS=H	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168	A 079		

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(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 079	Continued From page 14 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.	A 079		

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	AL11969794	A. BUILDING: _____ B. WING _____	01/29/2026

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A 079	Continued From page 15 b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident	A 079		

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A 079	Continued From page 16 care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that	A 079		

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A 079	Continued From page 17 resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate staffing to meet both the scheduled and unscheduled needs of residence for 13 out of 90 sampled residents (Resident #1 through #13) including assistance with activities of daily living. Findings included: During an interview at 6:38am the Assistant Director stated that he believed there were about 100 residents and about 10 residents under hospice care and 17 residents in memory care but was not sure. Observation on at 7:00am showed that there were six (6) employees that provided care for a census of 90 residents. A review of the facility incident log showed that there were 34 from to . Out of the 34 , 5 residents had	A 079		

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A 079	Continued From page 18 two or more , and 3 residents had serious injuries, including . During an interview on at 6:51am Staff D (caretaker/LPN) stated that there were five (5) staff working with him during the 11pm to 7:30am shift. Staff D further stated that he does room checks every two (2) hours or when responding to pendant calls. He stated that other staff do room checks every hour. When asked about he stated that Residents " all the time". Staff D stated that he did not know exactly why the happened but stated that it was probably "because the residents were getting up". During an interview on at 7:01am Staff F (caretaker) stated that she does room checks every 2 hours and would call the LPN for an assessment if a occurs. Staff F further stated she had not witnessed any during her employment. A review of the facility nightly wellness check policy showed resident care staff would check on residents at regular intervals during sleep hours to ensure that Resident's needs are met. During an interview on at 7:11am Staff G (caretaker) stated that she works from 11pm to 7:30am and that she checks up on residents every 2 hours. Staff G Identified Resident # 5 as someone who has multiple times. During an interview on at 7:39am Staff I (caretaker) stated that at times they are short staff and stated that she had to cover four (4) floors once. During an interview on at 8:20am	A 079		

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A 079	Continued From page 19 Staff L (caretaker) stated that she has been working at the facility since 2024 and stated that there could be more staff. Staff L further stated that "we do the best we can do." During an interview on at 8:35am the Resident Care Director stated that there were usually five (5) caretakers and a license practical nurse (LPN) from 11pm to 7:30am shifts and there were seven (7) caretakers and an LPN on the 7:00am to 3:30pm and 3:00pm-11:30pm shifts. Furthermore, the Resident Care Director stated that some staff are assigned to multiple floors during the night shift. The Resident Care Director stated resident care staff can take ten (10) minutes to respond to pendent calls, when asked how long staff would take to respond to calls from residents. During an interview on at 10:30am Staff M (caretaker) stated that they are busy and are short staff, when asked about staffing levels. A review of the all of the facility residents health assessments showed that 62 out of 90 resident were identified as risk/precaution; 51 out of 90 residents need assistance or total care with ambulation; 65 out of 90 residents need assistance or care with bathing; 60 out of 90 residents need assistance or total care with _; 39 out of 90 residents need assistance or total care with eating; 49 out of 90 residents need assistance or total care with grooming; 57 out of 90 residents need assistance or total care with toileting; 53 out of 90 residents need assistance or total care with transferring. Resident #1) During an interview on at 1:25pm Staff E stated that Resident #1 on .	A 079		

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A 079	Continued From page 20 She could not recall if Resident #1 pressed the pendent and stated that she did not have a private duty aide. She stated that Resident # 1 had a reported . A review of Resident #1 hospital records dated showed that she had a and had a closed of left , . During an interview on at 1:49pm Staff R stated that Resident # 1 twice on . Staff R stated that the first time that she she on her and was not taken to the hospital. She believed that resident while transferring from her wheelchair to the couch. She stated that resident did not press her pendant. On the second the day after she heard screaming and found Resident # 1 on the floor. Staff R stated that Resident # 1 lived with her husband and did not have a private aide and stated that Resident #1 did not use her call pendant. Staff R stated that she believed there was enough staff, and even with sufficient staff, residents will because they want to be independent. A review of Resident # 1 hospital records dated show that she suffered injury. Resident #2) A review of the facility incident log showed that on at or about 11pm staff heard screams coming from Resident #2's room and Resident #2 was found on the floor lying on her right side. Resident #2 was with a private duty aide when the occurred and reported right side , and was sent to the hospital. A review of Resident # 2 hospital records dated showed that she suffered a right	A 079		

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A 079	Continued From page 21 During an interview on at 9:55am The Director of Resident Care stated that Resident # 2 had a private aide with her when she and that she the night after she came from two-month rehab. The Director of Resident Care said that Resident #2 was very weak when she came and told the son about switching the private aide to the night because it was weekend. During an interview on at 1:21pm the Private Aide for Resident #2 stated that she was in the kitchen when Resident # 2 . The aide called staff and they came right away and called 911. Resident # 3) A review of the facility incident log showed that on at or about 5:38pm Resident # 3 while in the dining room. A review of Resident #3 hospital records dated showed that she suffered a left Resident # 4) A review of the facility incident log showed that on at or about 9:00pm Resident # 4 while transferring and did not activate his call pendent. Resident #4 on and During an interview on at 2:09pm Staff S stated that she was near Resident # 4 when he and found him on the floor in the kitchen after he screamed. She further stated that some residents needed more attention than others.	A 079		

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A 079	Continued From page 22 During an interview on at 2:20pm Staff T stated that she found Resident #4 on the floor after he pressed that wrong button on his assisted recliner, and that she did not know if he had before. During an interview on at 2:20pm Staff U stated that she found Resident #4 on the floor. Staff U further stated that Resident # 4 refused a nurse evaluation, however recalled that staff started making more frequent room checks after this happened. Resident # 5) Observation on at 8:05am showed that Resident # 5 was ambulating without assistance in his apartment. A private duty aide was in the room with Resident # 5. During an interview on at 8:06am Resident # 5's private duty aide stated that the residents had several times, and the family hired her to be with the resident. She stated that she slept in the bedroom with the resident. The private aide stated that she helped Resident # 5 with cleaning, ,, bathing and assist with other needs. The private aide stated that when she needed help with the resident, she would press the Resident 's call pendant. A review of the facility incident log showed that Resident #5 was found on the floor of his bedroom on at or about 5:29am. Resident #5 on three other occasions on ; ; and . During an interview on at 11:00am Staff Q stated that she responded to some Resident # 5 . She stated that on he was getting up from his recliner and slid to the	A 079		

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A 079	Continued From page 23 floor. She further stated that he had been , before the and was weak. Staff Q stated that he had experienced other because of . Staff Q stated that Resident #5 pressed his pendant after the and did not have a private duty aid with him at the time. Staff Q stated that we started to check on him more frequently after the . A review of the facility policy showed that when all attempts to prevent have been exhausted and the Resident continues to , the Resident may be required to have a private sitter to attempt to prevent future ; If the private sitter is not an option the Resident must be discharged to a more appropriate setting. During an interview on at 12:24pm with Resident Care Director stated that there were twelve (12) residents with private aid including Resident #2, Resident #5, Resident #7, and Resident #10. Resident # 6) A review of the facility incident log showed that on at or about 2:20pm Resident # 6 while attempting to stand up unassisted. Resident #6 on . During an interview on at 10:49am Staff P was with Resident #6 when she in the shower. Staff P stated that they do not need more staff in the memory care unit. Resident #7) A review of the facility incident log showed that on at or about 9:30pm Resident # 7 while in the dining room. Resident #7 on another occasion on .	A 079		

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A 079	Continued From page 24 During an interview on at 1:40pm Staff N stated that Resident #7 in the dining room and by the elevator. Staff N further stated that Resident #7 had no private aid and did not like to use a walker. Resident #8) A review of the facility incident log showed that Resident #8 was found on the floor of his bedroom on and . During an interview on at 10:40am Resident #8 stated that he has before. Resident # 8 further stated that when he calls for assistance he must wait about 20-30 minutes, when asked if he believed there was enough staff to assist him and his wife. A review of the response time logs from to for Resident # 8 room showed that on multiple occasions calls took 20-30 minutes. On the response time was 33 minutes; the response time was 43 minutes; the response time was 23 minutes; the response time was 26 minutes; the response time was 26 minutes; the response time was 36 minutes; the response time was 28 minutes; the response time was 37 minutes; the response time was 29 minutes; the response time was 36 minutes; the response time was 20 minutes; the response time was 33 minutes; the response time was 29 minutes; the response time was 2 hour and 48 minutes; the response time was 22 minutes. During an interview on at 1:40pm	A 079		

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A 079	Continued From page 25 Staff N stated that Resident 8 pressed his pendant when he lost his balance and there were no injuries. During an interview on at 2:09pm Staff S stated that she responded to a call from Resident #8 when she found him on the floor. Staff S further stated that she thinks that accidents happen and they make their rounds. Resident #9) During an interview on at 7:46am Resident # 9 stated that staff would take a long time to provide assistance. Resident #9 stated that the night before she needed help and asked staff for assistance to get dressed and staff did not help her after making her wait 45 minutes. A review of the nurse call system policy showed that call/alerts should be considered priorities until the care staff responded and determined that appropriate course of action. The policy also stated the call/alerts should be given equal priority. A review of the response time logs from to showed that there were 17 instances of 15-35 minutes response times. Including 21minutes for Resident #2; 20 minutes for Resident #4; 19 minutes for Resident #5; and 31 minutes for Resident #12. Resident #11) During an interview on at 8:34am Resident #11 says that she had been living at the facility for about 4 years and there use to be "40 residents now there about 200 people." and has difficulty getting to her doctors because there were no drivers.	A 079		

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A 079	Continued From page 26 Resident #12 and #13) Observation on at 7:57am in Resident #12 and 13's room there were dried feces on the bathroom floor. (photographic evidence obtained). During an interview on at 7:58am the Assistant Director stated that they cleaned the room once per week and would have the bathroom cleaned after he was asked about the dried feces. During an interview on at 9:20am the Assistant Director stated that they cleaned Resident #12 and 13's room. Class II	A 079		

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A 000	Initial Comments A complaint investigation (2025016837) was conducted at Mirabelle from to . The provider had deficiencies identified at the time of the survey.	A 000		
A 010 SS=G	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	A 010		

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A 010	Continued From page 1 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 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.	A 010		

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	AL11969794	A. BUILDING: _____ B. WING _____	01/29/2026

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A 010	Continued From page 2 (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. 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	A 010		

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A 010	Continued From page 3 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 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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the continued appropriateness of residence of one out of 14 sampled residents (5) The Resident had a change in condition that required 24-hour care and sustained multiple resulting in injuries. Findings included: A review of the facility's incident log showed that Resident 5 on , on , on and on . Interviewed on at 7:39 AM Staff I identified Resident 5 as having multiple at the facility. A review of Resident 5's progress notes showed that on the Resident was found on the floor unable to explain what happened and he was transported to the hospital via 911. Further review of Resident 5's progress notes showed that on he was found by staff on the floor outside of his bedroom unable to explain how he and he was taken to his private physician by his son. Further review of Resident 5's progress notes showed that on the Resident was found on the floor in his apartment complaining of , in the area, he was shivering, a clot was observed in his , and he was transferred to the hospital via 911. Interviewed on at 11:00 AM Staff M stated, "I was on duty when [Resident 5's] had the four during the daytime, not at nighttime. On	A 010		

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A 010	Continued From page 5 he tried to stand up from the recliner, did not have the strength and slid to the floor. After that he called me and I immediately called the nurse to come and check him, the nurse found that he had a clot that was obstructing the output. I was making my rounds around 10:00 AM and found him on the floor, he said that he went to the bathroom to poop and getting out of the bathroom he because he lost the strength, I told him to call me anytime he needs help, he said that he did not press the pendant because he could not do it. He was . We use [Resident care software program] and it was documented that he was and ; For his other two he was weak, he was with his sheet on the floor; apparently, he tried to get out of bed and slid to the floor, he had no injuries. When he pressed the pendant, he had already . He had no private aide. We started to check on him more frequently and started going to his room every half an hour." A review of Resident 5's health assessment dated showed diagnoses of , retention, acute , , , , , , exacerbation and ; had and , precautions and required assistance with all activities of daily living (ADL) of ambulation, bathing, , self-care, toileting, and transferring. A review of an email correspondence dated revealed that the Director of Resident Care communicated to Resident 5's daughter that the Resident required 24 hours care due to a change of his condition and urged her to contract the services of 24- hour private duty aide.	A 010		

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A 010	Continued From page 6 A review of an email correspondence dated revealed Resident 5's Daughter responded to the Director of Care acknowledging her father required a higher level of care and she was trying to obtain 24/7 care for the Resident. Interviewed on at 6:00 AM Resident 5's Private Duty Aide stated the Resident had several times and he had private duty aide service 24 hours a day. Class II	A 010		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards.	A 025		

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A 025	Continued From page 7 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, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain adequate supervision for 8 out of 13 sampled residents (Residents # 1, 2, 3, 4, 5, 6, 7 and 8) that had precautions and suffered at the facility, Residents # 1, 2 and 3 suffered . . .	A 025		

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A 025	Continued From page 8 Findings included: A review of facility records revealed that there were 34 reported at the facility during a 60-day period resulting in several injuries including . 1- A review of facility records showed that Resident #1 sustained 3 at the facility, on at approximately 8 PM she suffered a displaced , and , . On and on Resident #1 was found on the floor and sustained a hematoma on the right frontal area and on the left side of the respectively. A review of Resident #1's record showed that the health assessment completed on had her diagnosed with , , , and lymphoma, she was on precautions and required assistance with all activities of daily living. 2- A review of facility records showed that Resident #2 sustained a after she was found on the floor on at approximately 11 PM. A review of Resident # 2's record showed that the admission sheet had her diagnosed with folate deficiency, , , type 2 , hypercholesteremia, , , , , , , , status post . The health assessment completed on stated that she was on precautions, required supervision with eating and required assistance with ambulation, bathing, , grooming, toileting and transferring.	A 025		

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A 025	Continued From page 9 3- A review of facility records showed that Resident # 3 sustained a left following a at the facility on at approximately 5:30 PM. A review of Resident # 3's records showed that he suffered 4 at the facility, on he sustained on his and , requiring stitches after he was found on the floor. The Resident was also found on the floor on when he sustained scrapes to his right , on at 2:20 PM and on at 9 PM he attempting to transfer from his wheelchair and sustained skin breakage. 4- A review of facility records showed that Resident # 4 suffered 4 at the facility, on sustained on his and , requiring stitches after he was found on the floor. The Resident was also found on the floor on at 9:50 PM when he sustained scrapes to his right , on at 2:20 PM and on at 9 PM when he attempting to transfer from his wheelchair and sustained skin breakage. A review of Resident # 4's record showed that the health assessment completed on had him diagnosed with with left , , , status post Rhinovirus, , , , , , , ; he was on precautions and was independent with eating and required assistance with the rest of the activities of daily living. 5- A review of facility records showed that Resident# 5 experienced four at the facility. On at approximately 5:29 AM staff	A 025		

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A 025	Continued From page 10	A 025		

found him on the floor with no apparent injuries and was sent to the hospital for further evaluation. On at approximately 2:30 PM staff found him on the floor after he attempting to transfer and was referred to the hospital complaining of , in the area and a clot was observed in his . On at approximately 8:00 AM he was found in a supine position outside his bedroom and was unable to explain how he ended up on the floor. On at approximately 10:20 AM he was found on the floor next to his bed, he could not remember how he .

A review of Resident # 5's record showed that the health assessment completed on had him diagnosed with acute on , retention, acute , , , , , exacerbation, , ; he is on and precautions, required assistance with all activities of daily living.

6- A review of facility records showed that Resident# 6 had 2 , on at approximately 2:24 PM suffered a in the activities area when she attempted to stand up unassisted and slipped forward, striking her on a chair, she was transported by to the hospital. On at approximately 2:17 PM the resident in the shower in the morning, the [Resident Assistant] had her sitting on the shower chair when the had turned to grab an item, the chair was also on the floor, she had no injuries.

A review of Resident # 6's record showed that the health assessment completed on had her diagnosed with , , , , , , history of right

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A 025	Continued From page 11 , . She was on precautions and required assistance with all activities of daily living. 7- A review of facility records showed that Resident # 7 suffered 2 , on at approximately 9:31 PM and stated that she to her left side, with no injuries. On at approximately 9:57 PM she called her pendant and was found on the floor and sustained a to the left , stating that she had lost her balance. A review of Resident # 7's record showed that health assessment completed on had her diagnosed with severe , with , features, , , , , hearing loss. History of , history of left history of valve repair, nodules, , , recurrent . The resident was on precautions and needed assistance with bathing and eating, supervision with ambulation, , and self-care and was independent with toileting and transferring. 8- A review of facility records showed that Resident # 8 suffered 2 , on at approximately 4:21 AM was found on the floor after feeling , and attempting to sit on the couch and to the floor, he was transferred to the hospital for further evaluation. On at approximately 8:24 PM the resident suffered a hitting his , he was sent to the hospital. A review of Resident # 8's record showed that the non-dated health assessment had him diagnosed with shortness of , on precautions and requiring assistance with all activities of daily living.	A 025		

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A 025	Continued From page 12 On at 6:51 AM Staff D [Licensed Practical Nurse] stated that the residents constantly, mainly in the morning, when they try to get to the bathroom or they get up in the middle of the night and do not press the pendant or they press it and the staff takes 3 or 4 minutes to get to the resident and they do not want to wait. Most of the time they hit their heads. On at 7:11 AM Staff G, [Resident Assistant] stated that if there is a missing staff they divide one floor, that she was not trained by the facility on what to do when a resident , she was explained by another . On at 7:22 AM Staff H, ( ) stated that she was trained by another staff what to do in case of . On at 7:27 AM Staff K ( ) stated that she was trained by a more experienced who told her what to do in . On at 7:39 AM Staff I, ( ) stated that there have been many changes, some for better, some for worse, that if a staff calls sick, they have to work more, sometimes they call other staff to come to work and they cannot get anyone or they just don't call. Stated that last year she worked 4 floors in one day, that there have always been . There were residents with more , Resident# 5, 8, 3, 1 and 4, they have declined. On at 10:30 AM Staff M (Med Tech) stated that if someone calls sick, they have to work with more residents. On at 10:36 AM Staff J stated that there were a lot of residents on her floor and another	A 025		

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A 025	Continued From page 13 staff was needed. On at 10:40 AM Resident # 8 stated that he has had a few but had no injuries, that he called the staff and sometimes it would take up to half an hour for them to come to their room because they are busy with other residents. Resident # 8 shares the room with his wife, a review of the call pendant revealed that on it took staff 43 min 8s to answer the call bell to his room. On it took 33 min 12 s, on and it took 26 min, on took 28 min, on 37 min, on 36 min, 33 27 min and on it took 2 hours and 48 min. A review of the call pendant answer log for Resident # 2 revealed that it took 21 min for the call to be answered. A review of the call pendant answer log for Resident # 5 revealed that on it took 47 min to answer, same day another call took 21 min to be answered, on 54 min, on 50 min. Class II	A 025		
A 079 SS=H	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168	A 079		

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A 079	Continued From page 14 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.	A 079		

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A 079	Continued From page 15 b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident	A 079		

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	AL11969794	A. BUILDING: _____ B. WING _____	01/29/2026

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A 079	Continued From page 16 care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that	A 079		

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A 079	Continued From page 17 resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate staffing to meet both the scheduled and unscheduled needs of residence for 13 out of 90 sampled residents (Resident #1 through #13) including assistance with activities of daily living. Findings included: During an interview at 6:38am the Assistant Director stated that he believed there were about 100 residents and about 10 residents under hospice care and 17 residents in memory care but was not sure. Observation on at 7:00am showed that there were six (6) employees that provided care for a census of 90 residents. A review of the facility incident log showed that there were 34 from to . Out of the 34 , 5 residents had	A 079		

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A 079	Continued From page 18 two or more , and 3 residents had serious injuries, including . During an interview on at 6:51am Staff D (caretaker/LPN) stated that there were five (5) staff working with him during the 11pm to 7:30am shift. Staff D further stated that he does room checks every two (2) hours or when responding to pendant calls. He stated that other staff do room checks every hour. When asked about he stated that Residents " all the time". Staff D stated that he did not know exactly why the happened but stated that it was probably "because the residents were getting up". During an interview on at 7:01am Staff F (caretaker) stated that she does room checks every 2 hours and would call the LPN for an assessment if a occurs. Staff F further stated she had not witnessed any during her employment. A review of the facility nightly wellness check policy showed resident care staff would check on residents at regular intervals during sleep hours to ensure that Resident's needs are met. During an interview on at 7:11am Staff G (caretaker) stated that she works from 11pm to 7:30am and that she checks up on residents every 2 hours. Staff G Identified Resident # 5 as someone who has multiple times. During an interview on at 7:39am Staff I (caretaker) stated that at times they are short staff and stated that she had to cover four (4) floors once. During an interview on at 8:20am	A 079		

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A 079	Continued From page 19 Staff L (caretaker) stated that she has been working at the facility since 2024 and stated that there could be more staff. Staff L further stated that "we do the best we can do." During an interview on at 8:35am the Resident Care Director stated that there were usually five (5) caretakers and a license practical nurse (LPN) from 11pm to 7:30am shifts and there were seven (7) caretakers and an LPN on the 7:00am to 3:30pm and 3:00pm-11:30pm shifts. Furthermore, the Resident Care Director stated that some staff are assigned to multiple floors during the night shift. The Resident Care Director stated resident care staff can take ten (10) minutes to respond to pendent calls, when asked how long staff would take to respond to calls from residents. During an interview on at 10:30am Staff M (caretaker) stated that they are busy and are short staff, when asked about staffing levels. A review of the all of the facility residents health assessments showed that 62 out of 90 resident were identified as risk/precaution; 51 out of 90 residents need assistance or total care with ambulation; 65 out of 90 residents need assistance or care with bathing; 60 out of 90 residents need assistance or total care with _; 39 out of 90 residents need assistance or total care with eating; 49 out of 90 residents need assistance or total care with grooming; 57 out of 90 residents need assistance or total care with toileting; 53 out of 90 residents need assistance or total care with transferring. Resident #1) During an interview on at 1:25pm Staff E stated that Resident #1 on .	A 079		

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A 079	Continued From page 20 She could not recall if Resident #1 pressed the pendent and stated that she did not have a private duty aide. She stated that Resident # 1 had a reported . A review of Resident #1 hospital records dated showed that she had a and had a closed of left , . During an interview on at 1:49pm Staff R stated that Resident # 1 twice on . Staff R stated that the first time that she she on her and was not taken to the hospital. She believed that resident while transferring from her wheelchair to the couch. She stated that resident did not press her pendant. On the second the day after she heard screaming and found Resident # 1 on the floor. Staff R stated that Resident # 1 lived with her husband and did not have a private aide and stated that Resident #1 did not use her call pendant. Staff R stated that she believed there was enough staff, and even with sufficient staff, residents will because they want to be independent. A review of Resident # 1 hospital records dated show that she suffered injury. Resident #2) A review of the facility incident log showed that on at or about 11pm staff heard screams coming from Resident #2's room and Resident #2 was found on the floor lying on her right side. Resident #2 was with a private duty aide when the occurred and reported right side , and was sent to the hospital. A review of Resident # 2 hospital records dated showed that she suffered a right	A 079		

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A 079	Continued From page 21 During an interview on at 9:55am The Director of Resident Care stated that Resident # 2 had a private aide with her when she and that she the night after she came from two-month rehab. The Director of Resident Care said that Resident #2 was very weak when she came and told the son about switching the private aide to the night because it was weekend. During an interview on at 1:21pm the Private Aide for Resident #2 stated that she was in the kitchen when Resident # 2 . The aide called staff and they came right away and called 911. Resident # 3) A review of the facility incident log showed that on at or about 5:38pm Resident # 3 while in the dining room. A review of Resident #3 hospital records dated showed that she suffered a left Resident # 4) A review of the facility incident log showed that on at or about 9:00pm Resident # 4 while transferring and did not activate his call pendent. Resident #4 on and During an interview on at 2:09pm Staff S stated that she was near Resident # 4 when he and found him on the floor in the kitchen after he screamed. She further stated that some residents needed more attention than others.	A 079		

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A 079	Continued From page 22 During an interview on at 2:20pm Staff T stated that she found Resident #4 on the floor after he pressed that wrong button on his assisted recliner, and that she did not know if he had before. During an interview on at 2:20pm Staff U stated that she found Resident #4 on the floor. Staff U further stated that Resident # 4 refused a nurse evaluation, however recalled that staff started making more frequent room checks after this happened. Resident # 5) Observation on at 8:05am showed that Resident # 5 was ambulating without assistance in his apartment. A private duty aide was in the room with Resident # 5. During an interview on at 8:06am Resident # 5's private duty aide stated that the residents had several times, and the family hired her to be with the resident. She stated that she slept in the bedroom with the resident. The private aide stated that she helped Resident # 5 with cleaning, ,, bathing and assist with other needs. The private aide stated that when she needed help with the resident, she would press the Resident 's call pendant. A review of the facility incident log showed that Resident #5 was found on the floor of his bedroom on at or about 5:29am. Resident #5 on three other occasions on ; ; and . During an interview on at 11:00am Staff Q stated that she responded to some Resident # 5 . She stated that on he was getting up from his recliner and slid to the	A 079		

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A 079	Continued From page 23 floor. She further stated that he had been , before the and was weak. Staff Q stated that he had experienced other because of . Staff Q stated that Resident #5 pressed his pendant after the and did not have a private duty aid with him at the time. Staff Q stated that we started to check on him more frequently after the . A review of the facility policy showed that when all attempts to prevent have been exhausted and the Resident continues to , the Resident may be required to have a private sitter to attempt to prevent future ; If the private sitter is not an option the Resident must be discharged to a more appropriate setting. During an interview on at 12:24pm with Resident Care Director stated that there were twelve (12) residents with private aid including Resident #2, Resident #5, Resident #7, and Resident #10. Resident # 6) A review of the facility incident log showed that on at or about 2:20pm Resident # 6 while attempting to stand up unassisted. Resident #6 on . During an interview on at 10:49am Staff P was with Resident #6 when she in the shower. Staff P stated that they do not need more staff in the memory care unit. Resident #7) A review of the facility incident log showed that on at or about 9:30pm Resident # 7 while in the dining room. Resident #7 on another occasion on .	A 079		

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A 079	Continued From page 24 During an interview on at 1:40pm Staff N stated that Resident #7 in the dining room and by the elevator. Staff N further stated that Resident #7 had no private aid and did not like to use a walker. Resident #8) A review of the facility incident log showed that Resident #8 was found on the floor of his bedroom on and . During an interview on at 10:40am Resident #8 stated that he has before. Resident # 8 further stated that when he calls for assistance he must wait about 20-30 minutes, when asked if he believed there was enough staff to assist him and his wife. A review of the response time logs from to for Resident # 8 room showed that on multiple occasions calls took 20-30 minutes. On the response time was 33 minutes; the response time was 43 minutes; the response time was 23 minutes; the response time was 26 minutes; the response time was 26 minutes; the response time was 36 minutes; the response time was 28 minutes; the response time was 37 minutes; the response time was 29 minutes; the response time was 36 minutes; the response time was 20 minutes; the response time was 33 minutes; the response time was 29 minutes; the response time was 2 hour and 48 minutes; the response time was 22 minutes. During an interview on at 1:40pm	A 079		

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A 079	Continued From page 25 Staff N stated that Resident 8 pressed his pendant when he lost his balance and there were no injuries. During an interview on at 2:09pm Staff S stated that she responded to a call from Resident #8 when she found him on the floor. Staff S further stated that she thinks that accidents happen and they make their rounds. Resident #9) During an interview on at 7:46am Resident # 9 stated that staff would take a long time to provide assistance. Resident #9 stated that the night before she needed help and asked staff for assistance to get dressed and staff did not help her after making her wait 45 minutes. A review of the nurse call system policy showed that call/alerts should be considered priorities until the care staff responded and determined that appropriate course of action. The policy also stated the call/alerts should be given equal priority. A review of the response time logs from to showed that there were 17 instances of 15-35 minutes response times. Including 21minutes for Resident #2; 20 minutes for Resident #4; 19 minutes for Resident #5; and 31 minutes for Resident #12. Resident #11) During an interview on at 8:34am Resident #11 says that she had been living at the facility for about 4 years and there use to be "40 residents now there about 200 people." and has difficulty getting to her doctors because there were no drivers.	A 079		

Agency for Health Care Administration

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A 079	Continued From page 26 Resident #12 and #13) Observation on at 7:57am in Resident #12 and 13's room there were dried feces on the bathroom floor. (photographic evidence obtained). During an interview on at 7:58am the Assistant Director stated that they cleaned the room once per week and would have the bathroom cleaned after he was asked about the dried feces. During an interview on at 9:20am the Assistant Director stated that they cleaned Resident #12 and 13's room. Class II	A 079		