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
	AL11910374	A. BUILDING: _____ B. WING _____	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR COURT	3700 N. FLAGLER DR WEST PALM BEACH, FL 33406

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A 161	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. 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),	A 161		

AHCA Form 3020-0001

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

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A 161	Continued From page 1 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 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that, the facility failed to ensure that staff employee records contained an employment application with references for 4 of 6 sampled staff (Staff B, C, D, and J). The findings included: During an interview on at approximately 8:50 AM, Staff B (Assistant Administrator) was asked to provide employee records for Staff B, C, D, and J. 1) A review of the personnel file for Staff B (Assistant Administrator) revealed she was hired on . Further review revealed an employment application with no references. 2) A review of the personnel file for Staff C (Medication Technician -Supervisor) revealed she was hired on . Further review revealed an employment application with no references. 3) A review of the personnel file for Staff D	A 161		

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A 161	Continued From page 2 (Medication Technician) revealed she was hired on . Further review revealed an employment application with no references. 4) A review of the personnel file for Staff J (Food Service Coordinator) revealed she was hired on . Further review revealed an employment application with no references. During an interview on at approximately 4:15 PM, the team of surveyors met with the Administrator and the facility owner. They were informed of the findings. No additional information was provided. Class	A 161		
AL241	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the , agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation	AL241		

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AL241	Continued From page 3 was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and as	AL241		

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AL241	Continued From page 4 follows: a. An affirmative statement on the Alternate Care Certification for , , , , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name,	AL241		

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AL241	Continued From page 5 signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for . . ( ) form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be	AL241		

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AL241	Continued From page 6 provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the of the facility to facilitate and assist the resident in attending and arranging transportation to for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. include the Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must	AL241		

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AL241	Continued From page 7 prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation 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 appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, it was determined that the facility failed to maintain required admission and discharge records for Limited Mental Health (LMH) residents residing in the facility.	AL241		

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AL241	Continued From page 8 The findings included: This facility holds a Limited Mental Health (LMH) specialty license. During an interview on at approximately 8:50 AM, Staff B (Assistant Administrator) was asked to provide the admission and discharge log used to identify residents under the facility's LMH specialty license. Record review of the facility's LMH specialty license revealed that there was no admission and discharge log containing the names and dates for all LMH residents (admitted and discharged). During an interview on at approximately 4:15 PM, the team of surveyors met with the Administrator and the facility owner. They were informed that the facility failed to maintain the required admission and discharge log identifying all mental health residents. The Administrator acknowledged the findings. No additional information was provided. Class III	AL241		
A 000	Initial Comments An unannounced Relicensure with Limited Mental Health (LMH), Complaint (2025014863) and Generator Monitoring survey was conducted on at Windsor Court. The facility had deficiencies related to the Relicensure, LMH and Complaint at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency	A 010		

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A 010	Continued From page 9 429.26 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 nursing care.	A 010		

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A 010	Continued From page 10 (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. 59A-36.006	A 010		

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A 010	Continued From page 11 (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 are met:	A 010		

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A 010	Continued From page 12 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 record review, observation and interview, it was determined, the facility failed to ensure that an updated health assessment was completed as required by a significant change in resident's behavioral, medical or care needs in 1 of 3 records reviewed (Resident #12) .	A 010		

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A 010	Continued From page 13 The findings included: Upon review of the record for Resident #12 (Date of admission), the following concerns were identified: a) The following items were left blank on the health assessment dated : Elopement Risk In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing, or facility? Special Diet Instructions: Does the individual need help with taking his or her medications (meds)? Yes No b) On the health assessment dated Resident's assistance need for activities of daily living (ADLs) was listed as Independent for Ambulation, Bathing, Toileting, Eating, Grooming and Transferring. On a Physician's Order dated Resident was ordered Mechanically Soft Diet Dx Edentulism, c) Observations made at the time of survey did not align with the assessment in the following ways: On at approximately 9:54AM upon entry to the memory care unit, Resident #12 was observed in the bathroom off activity area on toilet, with door left open and his body visible to passersby. Surveyor observed Staff G (Direct Care Staff) providing supervision in the hallway just outside of the open door and Staff E (Direct Care Staff) providing assistance and standing	A 010		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 010	Continued From page 14 inside the bathroom with him. On at approximately 10:00AM, Surveyor observed Resident #12 being assisted from the bathroom by Staff G holding both his and walking before him while Staff E rolled a wheeled chair behind him until he was settled into a recliner in the activity room. On at approximately 11:35AM, Surveyor observed Resident #12 being assisted by Direct Care Staff to eat. Plated food was observed to come out of kitchen as described on the menu: steak strips, noodles, stewed tomatoes, bread with margarine. Direct Care Staff was observed to cut the food into smaller pieces as they spoon fed Resident #12. On in an interview at the time of lunch observation, Staff H (Resident Care Coordinator overseeing the dining area) reported Resident #12 is on a regular diet. On at approximately 1:55pm, Staff J provided an updated special diets list dated to this Surveyor. A review of the record revealed that Resident #12 was not included. At approximately 3:45pm on in an exit interview with Staff A (Administrator) and Staff K (Owner/Financial Officer), Surveyor identified discrepancies between Resident 12's health assessments and his presentation upon observation. Resident #12 was rated as Independent for ADL care but required assistance in toileting, ambulation and eating. Additionally, Resident #12 was ordered for a mechanical soft diet, but the facility was not observed to provide it. Both Staff A and Staff K were asked for documentation to clarify these discrepancies in	A 010		

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A 010	Continued From page 15 Resident #12's status but reported they did not have any additional documentation Class III	A 010		
A 032	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 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.	A 032		

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A 032	Continued From page 16 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: 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 interviews and record review, it was determined that, the facility failed to provide documentation of staff participation in elopement drills conducted for 5 out of 9 sampled staff (Staff A, D, E, G, and I). The findings included: During an interview on at 8:43 AM,	A 032		

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A 032	Continued From page 17 the Administrator was asked to provide documentation for the facility's elopement drills conducted twice a year for 2024 and 2025. 1) Review of the facility's personnel file for Staff A (Administrator) with hire date of revealed Staff A had no documentation of participating in elopement drills twice a year for 2024 and 2025. 2) Review of the facility's personnel file for Staff D (Med-Tech) with hire date of revealed Staff D had no documentation of participating in elopement drills twice a year for 2024 and 2025. 3) Review of the facility's personnel file for Staff E (Direct Care) with hire date of revealed Staff E had no documentation of participating in elopement drills twice a year for 2024 and 2025. 4) Review of the facility's personnel file for Staff G (Direct Care) with hire date of revealed Staff G had no documentation of participating in elopement drills twice a year for 2024 and 2025. 5) Review of the facility's personnel file for Staff I (Caregiver) with hire date of revealed Staff I had no documentation of participating in elopement drills twice a year for 2024 and 2025. During an interview with the Administrator on at 4:25 PM, she was informed that direct care Staff A, D, E, G and I did not participate in elopement drills for 2024 and 2025. The Administrator acknowledged the findings mentioned above. Class III	A 032		

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A 075	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observations and interviews the facility	A 075		

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A 075	Continued From page 19 failed to ensure a functioning automated external defibrillator ( ) was located onsite at the facility. The findings include: Record review revealed the facility had a census of 76 on . During a tour of the facility on at 11:00 AM, no observations of an automated external defibrillator ( ) machine was observed. During an interview on at approximately 3:30 PM with the Administrator, she stated the facility does not have an machine located onsite and she was not aware the facility was required to have a functioning machine. At the exit conference the Administrator acknowledged the facility is required to have a functioning machine onsite and is planning on purchasing an machine for the facility. Class III	A 075		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not	A 092		

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A 092	Continued From page 20 completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview it was determined, the facility failed to provide therapeutic diets as ordered by a health care provider in 1 out of 3 records reviewed. The findings included: On a review of the record for Resident #12 revealed an order for Mechanically Soft diet dated was included in the record. On at approximately 11:30am, Surveyor	A 092		

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A 092	Continued From page 21 requested Staff K (Owner/Financial Officer) verify accuracy of resident special diet list provided at entrance conference. List was dated . Resident #12 was not included. On at approximately 11:34am, Staff K brought updated special diets list dated . He confirmed this list is up to date. Resident #12 was not included. On at approximately 1:27pm, Surveyor observed posted special diet lists used in kitchen dated . In interview with Staff J (Food Service Coordinator) at the time of observation, it was reported this was the updated list used by kitchen staff to prepare meals for residents requiring therapeutic diets. Resident #12 was not included. On at approximately 1:45pm in interview with Staff J, it was reported that special diet lists are communicated to her approximately once a month by administrative staff. This was reported to include changes for current residents and new admissions. On at approximately 1:55pm, Staff J provided a second updated special diets list dated to this Surveyor. Resident #12 was not included. On at approximately 4:20pm in exit interview, Surveyor met with Staff A (Administrator) and Staff K to review concern with special diets. Both acknowledged they were unaware of Resident #12's order for a special diet. Class III	A 092		

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A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be .	A 152		

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A 152	Continued From page 23 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean, safe, and home like outdoor environment in the exterior courtyard and surrounding resident use areas, affecting all 12 of 12 residents residing in the facility. The findings include: On at approximately 3:40 PM, an observation of the exterior courtyard at the rear of the facility revealed, overgrown shrubbery extending into and obstructing the sidewalk on the courtyard. Multiple areas of the concrete walking area were broken, creating uneven surfaces and tripping hazards. The concrete courtyard flooring was uneven in the center with several cracked sections. Weeds were observed growing through the cracks. The concrete surface had black stains and the painted shuffleboard markings were faded. On at approximately 3:40 PM, an observation of the furniture located in the courtyard revealed; One rusted chair with a stained seat cushion, one rusted table with chipped paint that was wobbly when touched, several patio chairs without seat cushions; additional chairs had torn and stained cushions. Some chairs were broken or wobbled when moved. Patio tables with rust and chipped paint; some tables lacked accompanying chairs. Lounge chairs with stained and torn cushions, one lounge chair had no cushion. During an interview with the Administrator on at approximately 3:45 PM, while touring the courtyard, he stated that the courtyard area and the furniture located in the courtyard	A 152		

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A 152	Continued From page 24 needed cleaning and repairs. Class III	A 152		