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
	AL11953584	A. BUILDING: _____ B. WING _____	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS OF MELBOURNE	4451 STACK BLVD MELBOURNE, FL 32901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey, Complaint Investigation #2026004906 and generator monitoring were conducted at the Fountains of Melbourne Assisted Living Facility with Limited Nursing Services (LNS) on . The facility had deficiencies at the time of the survey visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (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 resident record review, facility's documentation and interview, the facility failed to ensure that appropriate supervision and care and services were provided by implementing mitigating defined systematic measures to maintain safety interventions for for 2 of 5 sampled residents (#1, #2) as required; and 2.The facility failed to give the correct dose of medication to resident #15. Findings: 1. A review of Resident #1's record revealed	A 025		

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A 025	Continued From page 2	A 025		

admission date . The 1823 Health Assessment dated listed medical history of history of , Aphasia, , affecting dominant right side, , Carotid aneurysm, , with , and . Resident #1 uses a walker to ambulate and needs assistance with self-administration of medications. She did not have any special precautions listed.

A facility note dated at 2:54 PM by LPN G documented Resident #1 was found crawling on the floor of her apartment. Resident #1 was crying and was unable to explain how she or what she was doing due to her aphasia. Resident #1 did not use her pendant for assistance. Resident #1 was complaining of right arm/ , . A small bump to her right side of forehead was observed. 911 was called and the physician and family were notified.

A facility note dated at 6:41 AM by LPN F documented resident #1 returned from the emergency room last night . It was reported that the resident had a on the right ring from the . A review of the hospitals after visit summary dated documented a closed nondisplaced of right ring , hematoma of frontal , closed of second (L2) and aneurysm without , .

This was the only documented for Resident #1 and the facility could not provide any documented evidence that a service plan for intervention to mitigate future was not put in place.

2. A review of Resident #2's record revealed

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A 025	Continued From page 3 admission date . The 1823 Health Assessment dated listed medical history of generalized , , of skin, , valve, , lymphedema and with unsteady gait. Resident #2 ambulates with a walker and needs assistance with self-administration of medications. She did not have any special precautions listed. A facility note dated at 9:24 PM by unlicensed caregiver E documented Resident #2 pressed her pendant when she arrived resident #2 was lying on the floor in the hallway on 3rd floor B side. Resident #2 stated was bumped by another resident operating an electric chair which caused her to . Resident #2 have multiples approximately a quarter sized on both , right and left ; first aid was provided to affected areas. Resident #2 refused services, couldn't find family by phone but was notified by voicemail message. Resident #2 physician was notified via fax. A facility note dated at 9:42 AM by LPN G documented Resident #2 said another resident with an electric wheelchair hit her from behind last night ( ) causing her to forward and she obtained multiple . Observed left and right , able to apply steri-strips to right . Cleansed and covered right lower extremity large applied steri-strips cleansed and covered. Advised resident #2 to hold off on stockings due to . She verbalized understanding. Resident #2 used her walker throughout the apartment and denied any acute , .	A 025		

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A 025	Continued From page 4 A facility note dated at 8:17 AM by unlicensed caregiver B documented around 7 PM Resident #2 decided to call 911 because she was in , from earlier this morning. A facility note dated at 5:25 AM by unlicensed caregiver D, Resident #2 found on the floor. Resident #2 had on her left , right and left . Refused 911 call; faxed physician; notified family with no answer and left message. B/P ; 68; , . Resident #2 had only two while at the facility that was documented. The facility could not provide any documented evidence that a service plan for intervention was put in place to mitigate future . A review of the facility's policy and procedures dated documented that all residents evaluated for risk should have their service plan developed and updated accordingly. Furthermore, this policy and procedure should reduce the number of and evaluate environment to maintain safety from . The facility did not follow their policy and procedures for resident #1 and resident #2 after their /incidents. On at 3:20 PM, an interview with the Administrator confirmed the findings and further stated that the facility must document all service plans and meetings for all residents that are risk when discussing future interventions. 3. Review of Resident #15's record revealed a health care provider's order, dated , to decrease to 30 milligrams (mg) once	A 025		

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A 025	Continued From page 5 daily. Review of the resident's , medication observation record revealed the facility gave the 30 mg every 12 hours from through . On at 2:30 PM, the Administrator said the facility made a mistake and gave the wrong dosage. (Photographic Evidence Obtained) Class II	A 025		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;	A 055		

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A 055	Continued From page 6 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued	A 055		

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A 055	Continued From page 7 medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure 1 of 6 sampled residents received assistance with self-administration of medication (#10). Findings: Review of resident #10's record revealed a facility admission on . A 1823 health assessment indicated a medical history of assistance with self-administration of medications. On at 10:43 AM, observation revealed unsecured medications consisting of ,	A 055		

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A 055	Continued From page 8 , Preser Vision, , and Budes/ in the resident's room. On at 10:45 AM, resident #10 stated the facility does his medications but he takes the himself for . Adding, Unlicensed Caregiver A left his Budes/ after he used it. On at 10:50 AM, Unlicensed Caregiver A entered the resident's room stating, she completed his medication pass, and this was the first time she's left the Budes/ in the room. On at 10:53 AM, the Team Lead entered the resident's room confirming the facility does resident #10's medications. Further stating, the resident does not self-administer and should not have the over-the-counter (OTC) , , Preser Vision, , in his room. The Team Lead removed the meds. On at 10:55 AM, the Team Lead reviewed the medication observation record (MORS) at the med cart and confirmed the resident did not have any orders to self-administer. On at 3:15 PM, the Administrator stated she was not aware of the medications found in resident #10's room. After review of the , MORs she stated sometimes the self-administration off the new MORs each month. The Administrator was made aware the prior MORs were reviewed. There were no physician's orders to self-administer medication or that the resident was able to keep in the room. On at 5:08 PM, the Administrator and Executive Director confirmed the findings.	A 055		

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A 055	Continued From page 9 (photographic evidence obtained) Class III	A 055		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician	A 093		

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A 093	Continued From page 10 supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider	A 093		

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A 093	Continued From page 11 of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˽ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, facility's record reviews, and interviews, the facility failed to maintain 6 months of dated menus approved and signed by a licensed dietician. Findings:	A 093		

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A 093	Continued From page 12 The Culinary Director was asked to provide 6 months of dated signed menus for review. On at 12:30 PM, the Culinary Director provided four (4) copies of menus titled week 1, week 2, week 3, and week 4. Adding, these are the menus that he uses each week and creates a copy to be posted daily for the residents. Review of the menus revealed a signature with no dietician license number, no date reviewed, and unable to determine the dietician's name. On at 12:40 PM, the Culinary Director stated the facility has a new dietician that started in and she was now approving the menus, but he continued to use the menus from the prior dietician to create the daily menus. On at 1:20 PM, the Culinary Director provided unsigned menus for review from which were not signed or dated by a dietician. Adding, he goes into the computer software to generate and print the daily menus. On at 2:05 PM, the Executive Director stated the former dietician whose signature was determined on the week 1 - week 4 menus did not date the menus and they don't know why. On at 2:20 PM, the Culinary Director provided new copies of week 1 - week 4 menus, print date signed by the new dietician without the registration or license number and no annual date reviewed. On at 3:22 PM, the Administrator stated she was made aware the facility did not have dated, signed 6 months of menus and confirmed the new dietician started in	A 093		

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A 093	Continued From page 13 The facility failed to maintain approved menus that included the original signature of the reviewer, registration or licensed number, and date reviewed by a licensed dietician. (photographic evidence obtained) Class III	A 093		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a	A 160		

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	AL11953584	A. BUILDING: _____ B. WING _____	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS OF MELBOURNE	4451 STACK BLVD MELBOURNE, FL 32901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 14 resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 160	Continued From page 15 local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's . . prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on the facility's documentation review and interview, the facility failed to obtain a Department of Health (DOH) group care report annually as required. Findings:	A 160		

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
	AL11953584	A. BUILDING: _____ B. WING _____	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS OF MELBOURNE	4451 STACK BLVD MELBOURNE, FL 32901

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A 160	Continued From page 16 A review of the last DOH group care inspection report dated expired on . On at 3:45 PM, an interview with the Administrator confirmed the finding and could not provide the current group care inspection report. (Photographic Evidence Obtained) Class III	A 160		