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
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 and a generator monitoring was conducted at Bishop Grady Villas Assisted Living Facility on and . The provider had deficiencies at the time of the 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) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 1 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 review of facility's documentation, resident record review and interview, the facility failed to ensure to provide appropriate supervision for 1 of 2 sampled residents (#1) during a with injury occurred and a delay of higher level of care was not immediately provided as required. Findings: The facility reported an incident for Resident #1 on . The resident sustained a and complained of and , and was sent out to the hospital on (3 days later). The delay was because the facility's Registered Nurse	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 2 (RN) called his doctor's office Nurse Practitioner next day first. A review of Resident #'1's record revealed an admission date of . The last 1823 Health Assessment dated listed medical history of type 2, Memory loss, , , , , and , , . He had with . He was a risk and ambulated with a walker. He needs assistance with bathing, , grooming and toileting, supervision with ambulation and eating in activities of daily living (ADLs). Also, he needs assistance with self-administration of medications. A facility note on at 3:24 AM by Caregiver D documented resident #1 told her that he in his room. Checked for and marks on his body, none observed. Resident #1 said that he on his side and thinks but did not remember. Resident #1 was observed walking fine as he went to breakfast; he went to get a spoon and talking with peers. Later after breakfast, resident #1 asked for help to place him into bed. Observed resident #1 got into his own bed with no problem. Advised him to get closer to the wall so nothing would occur. A facility note on at 5:43 AM by Caregiver D documented she checked on resident #1 during her last rounds before getting off work, and resident #1 told her he was fine, but his bed was hard and he was sitting in his chair watching TV. A facility note on at 11:33 AM by the facility's Registered Nurse (RN) documented called Cloud Care Medicine for a tele-visit with the APRN with resident #1 tomorrow (at	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 3 11:30 AM) and further said that if they get a cancellation today or earlier tomorrow morning then they will do the tele-visit. A facility note on at 7:48 AM by Caregiver E documented resident #1 was acting normal during her shift. Caregiver E asked resident #1 if he had any discomfort from his ? Immediately resident #1 started raising his voice and saying things like his hurt and he was in . There were no visible . He was assisted with range of motion exercises, and he did not express any . He asked to take him to breakfast and asked for . He was given his as needed . He said he felt a little better and he didn't know. Follow up with the nurse. A facility note on at 9:11 PM (approximately 11 hours later) by Lead Caregiver F documented resident #1 body was stiff and he was complaining of and . Assisted him to get off the bed and into his chair. Resident #1 requested he needed . Vitals checked his , . He ate dinner in his room tonight. Assisted him into bed. He needs to be monitored as he will need help with the bathroom during overnight and help switch sides. A facility note on at 4:59 AM by Caregiver G documented resident #1 had been checked during the night. He was complaining that his and hurt. He was given as needed at 12:33 AM (4 hours ago). Assisted him to the bathroom and he was unsteady when walking, he asleep a half hour later. At 3 AM, he was still asleep. At 4:30 AM, he was awake and requesting help to the bathroom then assisted him to bed. He was still complaining of , to his and .	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 4 A facility note on at 1:26 PM by Caregiver E documented resident #1 was still complaining of and . He was given as needed at 7 AM and 1:15 PM. Resident #1 stated that the medicine was not helping. A facility note on at 4:28 PM by the facility's RN documented resident #1 was scheduled for his 11:30 AM tele-visit today with the APRN. They did not call for the tele-visit and called the clinic, and the tele-visit would be rescheduled today at 4:40 PM. A facility note on at 4:40 PM by the facility's RN documented the APRN from tele-visit sent a prescription to pharmacy for for . She will order for his and left . She will also request a half rail hospital bed for safety so when resident #1 gets out of his bed. A facility note on at 5:10 PM by the facility's RN documented the Advanced Practitioner Registered Nurse (APRN) sent the new prescription to pharmacy of for . She will send order for of and left . Not stat order, so he can go to Simon Med tomorrow morning as a walk in, and when staff are available to take him. The APRN will provide an order for half rail hospital bed for safety when he is getting in and out of bed. A facility note on at 4:36 AM by Caregiver G documented resident #1 was awake when checked at 12:30 AM. He was complaining of his and was very painful. He was given as needed medication for . Checked on him again a half hour later, and he said his and were still hurting. It was suggested to try to	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 5	A 025		

sleep on the left side and wedge a pillow to his . At 3 AM, checked on him and he was awake but in bed. He said that his and were still hurting. He only can have his painkillers every 6 hours.

A facility note on at 7:40 AM by Caregiver E documented that resident #1 had soiled his protective underwear and bed. His bedding and clothes are being washed. He was still complaining of , but seemed to be in better spirits.

A facility note on at 1:31 PM by Caregiver E documented that resident #1 got his , completed today at the imaging center. They wanted Caregiver E out of the room but resident #1 kept screaming for Caregiver E to stay in the room with him. They allowed it. Redirected him to breathe and calm down so they can capture the images.

There was no documented evidence for when Resident #1 finally went out to the hospital on (Friday), 3 days later after his on and there was no documentation that facility made any follow up efforts with Resident #1 being in the hospital over the weekend (-).

A review of the facility's many policies and procedures, and the facility could not provide a risk policy and procedures for high risk for residents and explained how the facility would mitigate with interventions.

A review of the facility's change in condition and significant health event policy effective date documented the purpose was to protect resident's health and safety by promptly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 6 recognizing significant changes, arranging appropriate healthcare, communicating with the resident's health care provider and responsible party. In further review the responsibilities of the direct care staff must promptly report changes, injuries, symptoms and safety concerns. The nurse must perform a nursing assessment and document substantial changes that may necessitate relocation. The Manager on Duty must support a timely clinical escalation, emergency response decisions. An example of a potential significant change includes , sudden behavioral changes, , , , , suspected , uncontrolled , , , , refusal of essential medications and signs of /neglect. An immediate response and triage required to call 911 immediately for life-threatening symptoms or when emergency medical attention is needed. A review of the facility's emergency transport and emergency department escort effective date documented this policy applies to responses to medical emergencies or urgent medical needs requiring transportation to an emergency department (ED), urgent care or other higher level of care. The facility must respond promptly and appropriately to medical emergencies to protect life and safety of the residents. The facility failed to send Resident #1 to the hospital emergency room immediately to ensure there was no additional injuries such as a injury. Resident #1 had been complaining of , and , for 3 days. Resident #1 does not have the ability to determine, understand and remember if he had other injuries. Resident #1	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 7 has a intellectual , and . On at 3:18 PM, an interview with Caregiver D who Resident #1 initially reported his to on during the overnight shift and she confirmed that Resident #1 told her he had on his left side but did not remember much about it. She did a full body check and did not see any or injuries. She said that he was walking and talking and feeling fine. It was further asked when Resident #1 reported to her a couple hours later while doing her rounds that he said his bed was hard and he was sitting in his chair watching TV at 5:43 AM, Caregiver D was asked if Resident #1 stated why he was stating his bed was hard? Caregiver D answered no that she did not ask that question and did not follow up. On at 3:30 PM, an interview the facility's RN and requested documentation of her completed body assessment ( ) after she was aware that Resident #1 had on (day before). The facility's RN answered that she visually completed a body assessment and immediately called the nurse practitioner to get a tele-visit; and could not provide any documentation of that she completed a body assessment on Resident #1 for any , or injuries. The facility's RN thought that calling the nurse practitioner was suffice because Resident #1 was alert, still moving and walking around. On at 4 PM, an interview with the facility's RN nurse confirmed that Resident #1 returned to the facility today and he had a . She further stated that he did not have any surgery and will require to use a wheelchair for now; he was prescribed new medication: 500mg and will begin physical	A 025		

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
	AL11966140	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

(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 025	Continued From page 8 , , next week. The facility's RN confirmed the findings and said that anytime the residents report that they the facility sends them out to the hospital due to their . On at 7 PM, an attempted telephone interview with Caregiver E, no answer. Left voicemail message. No returned call . On at 7:10 PM, an attempted telephone interview with Lead Caregiver F, no answer. Left voicemail message. No returned call . On at 7:15 PM, an attempted telephone interview with Caregiver G, no answer. Left voicemail message. No returned call . On at 4:37 PM, a telephone exit interview with the Administrator confirmed the findings. (Photographic Evidence Obtained) Class II	A 025		