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
	AL11969886	A. BUILDING: _____ B. WING _____	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBA COURT RESIDENCES	115 WASHINGTON ST NEW SMYRNA BEACH, FL 32168

(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 (complaint numbers 2025016963, 2026005085, 2026005812, & 2026007735) was conducted at Alba Court Residences on May 18-22, 2026. Deficiencies were identified at the time of the survey.	A 000		
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 height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, chest 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	A 152		

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A 152	Continued From page 1	A 152		

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 threadbare.

This Statute or Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure its systems were maintained in good working order for the 43 residents of the facility.

The findings include:

1. During an interview with Employee A, Medication Technician, on 5/18/2026 at 10:00 AM, she was asked if there were any problems with the air-conditioner not working properly in any resident rooms. She stated there were a couple of rooms on the second floor of the assisted living (AL) side of the facility but that it was "really bad" on the Memory Care Unit. She stated the residents on the AL side have been given portable air conditioners and they leave their door and windows open to stay cool.

During an observation of room 227 at 10:47 AM on 5/18/2026 with Employee A, the air temperature was taken using an Agency for Health Care Administration (AHCA) hygrometer and found to be at 81.1 degrees.

During an observation of room 220 on the Memory Care Unit at 11:15 AM on 5/18/2026, the air temperature was taken using an Agency for Health Care Administration (AHCA) hygrometer and found to be at 84.5 degrees. The windows in the room were open. The findings were confirmed

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A 152	Continued From page 2 by Employee D, Medication Technician. The wall thermostat was set at 67 degrees. During an interview on 5/18/2026 at 12:05pm, the Administrator was notified of temperature concerns. The Administrator confirmed they were having issues with the air conditioning in the parts of the building that used a specific unit. When the issue was identified, they attempted to get it repaired but because of the brand of air conditioner, a certified company with specific parts needed to be used. When they located a certified company, the technicians verified what was wrong, and ordered the brand-specific parts. When asked about the option for affected residents to relocate, the Administrator explained the residents with complaints wwere provided a temporary air conditioner unit/window unit while the repairs were being made. Residents were told to let her know if they needed additional fans or a portable air conditioning unit. She Administrator said they were doing temperature checks, and her expectation was the staff in Memory Care were monitoring the residents, where the residents may not be able to convey issues with temperatures. "That's why I have staff up there to monitor and they are smart enough to use fans or to take them outside on the balcony where it is shaded." A second observation of room 220 at 12:12 PM on 5/18/2026 found the temperature in the room near the bed closest to the door was 82.4 degrees using the AHCA hygrometer. The temperature just inside the door in the kitchen area was 81.1 degrees. The Memory Care Unit was observed on 5/18/2026 at 1:48 PM with the Administrator present. The temperature in room 220 was taken	A 152		

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A 152	Continued From page 3 again and registered at 82 degrees using the AHCA hygrometer. The Administrator closed the blinds and set the wall thermostat at 65 degrees. During an interview with Employee E on 5/19/2026 at 11:55 AM, she was asked why there were two residents in room 220 who were not moved to rooms with operating air-conditioners. She stated the facility had no other cool rooms. During an interview on 5/19/2026 at 12:30 PM, the Administrator was informed that room 220 was at 82.4 inside the room that was assigned to two residents. Blinds were pulled up and the sun was shining towards the windows. The Administrator explained she spoke to the staff on the Memory Care Unit about moving the residents, and acknowledged the need to have a plan to monitor residents until the broken units got repaired. During an interview on 5/19/2026 at 1:05 PM, the Resident Care Coordinator, (RCC) stated they had meetings to review this and staff knew to check on the residents every one to two hours. When asked if there was any documentation of training or rooms checks, the RCC stated "probably not." At 1:20 PM on 5/19/2026 the RCC explained the staff moved the resident from 230 into 220 on their own without management's knowledge, because the resident in 230 didn't want to be alone. She stated she didn't know why staff placed them in a room with the broken unit instead of having them room together in room 230 that wasn't affected. An observation of the facility's Memory Care Unit on 5/22/2026 at 3:05 PM found 6 residents sitting	A 152		

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A 152	Continued From page 4 in the activity room. The temperature was taken in the room using an AHCA hygrometer and found to be at 82.7 degrees. 2. During an interview with Resident #13 on 5/18/2026 at 10:00 AM, he stated he was having a problem getting his laundry because the washer and dryers at the facility were always broken. During an interview with Resident #6 on 5/18/2026 at 10:36 AM, she stated she was having to have family do her laundry because the facility washers and dryers were not working. An observation of the laundry area was made with Employee A on 5/18/2026 at 11:22 AM. There were four washers and dryers observed. One washer was labled as broken, and Employee A stated the dryers do not work properly. She stated to get one load dry you have to run it all day. She also stated the lint traps were missing their filters. An observation at the time revealed the four dryers did not have lint filters and one of the dryers had stopped and the clothing inside was still damp. (Photographic evidence obtained.) The laundry room was observed again with the Administrator on 5/19/2026 at 11:05 AM. The Administrator confirmed the dryers did not have filters in their lint traps. Two of the dryers had clothes in them that were still damp. The Administrator reset the dryers. During another interview with Employee A on 5/19/2026 at 11:55 AM, she stated the overnight staff had started the laundry for Resident #13. She stated that when she came in this morning, she restarted the dryer. During an interview with	A 152		

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A 152	Continued From page 5 Employee E at the same time, she stated that many of the residents had dirty clothes in the laundry. She stated they cannot do the laundry because the washers and dryers are broken. She further stated that Resident #10 had told her she did not want to come to lunch because she did not have any clean clothes to wear. The laundry room was visited again on 5/19/2026 at 12:15 PM. Both dryers that were reset by the Administrator had stopped. The clothes inside were damp. The findings were confirmed by the housekeeper, Employee F, at the time of observation. 3. During an observation of room 217 on the Memory Care Unit on 5/18/2026 at 11:07 AM with Employees D and E. The window in the room was observed to be opened. Further observation of the window found there were not devices/stoppers in the window tracks to prevent the window from opening wide enough for a person to exit. The findings were confirmed by Employee D and E who were in the room at the time. During an observation on 5/18/2026 at 11:15 AM on the Memory Care Unit in room 220, two of the three windows in the room were observed to not have any devices/stoppers in the window tracks to prevent the windows from opening all the way. The findings were confirmed by Employee D. Photographic evidence obtained. Class III	A 152		