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
	AL11969348	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY BRANDON, LLC	1320 OAKFIELD DR BRANDON, FL 33511

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A 000	Initial Comments A complaint investigation (#2026009833, #2026004179, #2026006971) was conducted at Ambiance at Brandon on . Deficiencies were identified at the time of the survey. A Class I deficiency was found at tag A0030. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. Ambiance at Brandon failed to initiate , , ( ) on a resident with a full code status which placed 69 residents with full code status at risk of immediate danger or harm. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 5:00 p.m. The census at the start of the survey was 120. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES.	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and	A 030		

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A 030	Continued From page 2 , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and	A 030		

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A 030	Continued From page 3 with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.	A 030		

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A 030	Continued From page 4 (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the	A 030		

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A 030	Continued From page 5 residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever	A 030		

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A 030	Continued From page 6 possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor resident rights to provide adequate and appropriate health care by not providing immediate emergency care for one resident (Resident #12) of one who was a full code and was found unresponsive in the Memory Care Unit. Additionally, the lack of facility following emergency policies and procedures, and the delay of initiating emergency medical treatment, posed a direct threat to Resident #12, who and continues to place all sixty-nine remaining residents with a full code status at imminent risk of harm or . Findings included: A review of the facility census and list of residents identified as full code, conducted on , revealed sixty-nine current residents who wanted , , ( ). A record review for Resident #12, conducted on	A 030		

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A 030	Continued From page 7 , revealed Resident #12 was admitted on and was discharged on due to her . Resident #12's Agency for Healthcare Administration Health Assessment Form 1823 (1823) dated revealed Resident #12 had diagnoses of , and a . Resident #12 was with and was non-ambulatory. Resident #12 required assistance with eating and had a regular diet. A ( ) Resident Signature Acknowledgement Page dated noted Resident #12 wanted , , ( ). Additionally, a review of a document entitled " and Advanced Directives" not dated revealed "The community will administer , ( ) to residents who do not have a . (Photographic evidence obtained). A review of video footage of Resident #12's room, conducted on , revealed on at 11:52 AM Staff G and Staff H came into Resident #12's room pushing Resident #12 in a wheelchair. Resident #12 was , , pale in color, and appeared to not be breathing. Staff H picked Resident #12 up out of the wheelchair and placed her in bed. Resident #12 appeared limp and did not provide assistance in the transfer. Staff H then removed Resident #12's from her . Staff H told Staff G to call 911. Staff H began lifting and bending Resident #12's up toward her and repeatedly while talking to her without getting a response. At 11:53 AM, Staff H called Resident #12's first name repeatedly and rubbed Resident #12's with no response. Staff H pulled out a cell phone to type a message at 11:54 AM before taking off Resident #12's shoes	A 030		

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A 030	Continued From page 8 and socks and pulling her pantlegs down over her calves. At 11:55 AM Staff H picked up Resident #12's from the bed and put them on the table by the bed before adjusting her on the pillow. At 11:55 AM the Maintenance Director arrived in the room with Staff G. The Maintenance Director said to "call 911 right away" to Staff G. Staff I arrived seconds later. Staff H said, "I don't have the address, or I would have done it." The Maintenance Director said the address and "nonresponsive." Staff G began to dial 911. At 11:56 AM Staff I said she was calling 911 so Staff G cancelled her call. Staff I left the room talking on the phone. Staff H began hitting the bottom of Resident #12's while talking to the resident with no response. Resident #12's right from Staff H's arm to the bed. Staff H said, "she's still alive, she is pulling away" and picked up Resident #12's right again and was hitting the soles of both while repeatedly lifting and bending Resident #12's to her . Staff G rubbed Resident #12's with no response. The Maintenance Director left the room.. At 11:58 AM, Staff G wiped Resident #12's right with a wipe and held her . Staff H patted the bottom of Resident #12's and stated, "she's , look how she's pitting." At 12:00 PM, Staff I walked into the room on the cell phone and Staff H stated to Staff I "No, we need 911 to come". Staff I stated "yes, I already called 911." Staff H saw wetness on Resident #12's pants and stated that she had defecated on herself and that she was gasping for breath. However, Resident #12's did not appear to rise and . There was no visible breathing observed or heard on the video. Staff I asked Staff G and Staff H if Resident #12 was . Staff H stated "no, she is alive." EMTs arrived at 12:01 PM and asked if Resident #12 was a . Staff I stated she did not think she was a and left the room to	A 030		

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A 030	Continued From page 9 check. EMTs stated they did not feel a , . EMTs started at 12:02 PM. Staff I returned to the room and Staff H stated, "she is a ." EMTs asked for the yellow form. Staff I left the room again. Staff H stated "she just gasped for air before you guys came in." EMTs stopped at 12:09 PM. One EMT stated "the original monitored rhythm was (, ,) and now it is , " (absence of heartbeat). At approximately 12:10 PM the paramedic asked Staff I if Resident #12 ate about an hour before and Staff I responded "yeah." During an interview on at 9:41 AM, Staff G (unlicensed resident care aid) stated she was trained in and first aid. Staff G stated ( ) papers were documented on pink paper. Staff G stated she gave Resident #12 juice for lunch but Resident #12 was not eating. Staff G stated she applied first aid without any further details and tried to keep Resident #12 alive during the incident on at approximately 11:48 AM . Staff G stated Staff H and herself initially were the only ones in Resident #12's room but later said Staff I did come in. Staff G stated that none of the employees did on Resident #12. Staff G stated Resident #12 was alive when they brought her to her room and that she tried to breathe three times. Staff G stated she checked for a , on the right side of Resident #12's . . During an interview on at 9:59 AM, Staff H (unlicensed medication technician) stated she remembered taking Resident #12 to her room on approximately at 12:00 PM. Staff H stated she picked up Resident #12's and her color was not getting better. Staff H stated staff called Emergency Medical Response Technicians (EMTs) and Resident #12 was still	A 030		

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A 030	Continued From page 10	A 030		

breathing. Staff H stated Resident #12 took one more last breath as emergency medical personnel arrived and put Resident #12 on the floor. Staff H stated Resident #12 had not eaten and was waiting for her lunch. Staff H stated she did not know why Staff G and Staff I did not get the automated external defibrillator ( ). Staff H stated Staff G, Staff I and herself were in the room with Resident #12 during the incident.

During an additional interview on at 2:35 PM, Staff H stated she checked Resident #12's , in her during the incident. Staff H pointed to the right side of her own showing where she checked Resident #12's , . Staff H reported the facility did not have Resident #12's form at the facility.

During an interview on at 12:56 PM, Staff I (unlicensed medication technician) stated she went to Resident #12's room on at approximately 12:00 PM and was trying to call an ambulance and saw Staff H doing the -and-forth movement of Resident #12's . Staff I stated she saw Staff G and Staff H in the room with Resident #12 and Staff G ran to her and she called 911. Staff I stated that she had gotten Resident #12 up that morning and everything was fine. Staff I stated when Resident #12 would not respond to her in the room during the incident, she knew something had to be wrong. During an interview at 2:55 PM, Staff I stated she checked Resident #12's , on her . Staff I stated Resident #12 was already when she arrived in the room. Staff I stated the EMTs just wanted the form. Staff I stated Resident #12 had not eaten lunch but was waiting for lunch. Staff I reported she did not have a form for Resident #12.

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A 030	Continued From page 11 A record review of the self-reported adverse incident report revealed Resident #12 had an incident in the dining room on . Resident #12 leaned forward in the chair and became unresponsive at approximate;y 11:50 AM on . Staff H and Staff G assessed her unresponsiveness and transferred Resident #12 to her room for further evaluation and attempted to arouse her. The report revealed Resident #12 had shallow breathing and EMTs reported a , of thirty-two beats per minute when they arrived. was initiated by EMTs and not by staff. A review of facility progress notes by the Memory Care Director dated at 9:53 AM revealed Resident #12 was in the dining room on at 1:51 PM when the resident leaned in the chair and became unresponsive. The staff immediately assisted Resident #12 to her room and transferred Resident #12 to her bed. The staff notified 911 and the EMTs arrived and initiated . EMTs pronounced Resident #12 at 12:09 PM. An attempted record review of a , policy or procedure revealed there was no , policy or procedure available for review. An attempted record review of an policy or procedure of use revealed there was no policy or procedure available for review. An attempted record review of the facility's policy revealed no formal policy available for review. The facility's residency agreements revealed the policy is only to be completed if a resident had consulted with his or her health care provider and had made a competent decision to endorse it.	A 030		

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A 030	Continued From page 12 A record review of Staff G's employee file revealed a and first aid card that expired on . A record review of Staff H's employee file revealed Staff H was not currently certified in and first aid training. An observation conducted on at 2:40 PM, revealed there was an in the Wellness Office in assisted living and the memory care unit. During an interview on at 2:59 PM, the Maintenance Director stated there was no video available from the incident on between 11:55 AM - 12:10 PM of the Memory Care dining room. During an interview on at 1:20 PM, the Administrator stated there was one in the memory care unit and one in assisted living. At 1:50 PM, the Administrator stated the facility did not have a specific policy. During an interview on at 2:06 PM, Resident #12's family member stated she had put a camera in Resident #12's room to keep an on her due to previous concerns with care and treatment. The family member stated the facility did not have Resident #12's on file. The family member stated the facility was not performing in the video footage and it was clear that Resident #12 was . The family member stated there was an autopsy for Resident #12 and the medical examiner stated Resident #12 choked on a brussels sprout. The family member stated there was no rising and falling of the and Resident #12 remained unresponsive throughout the video footage.	A 030		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13 Additionally, the family member stated staff did not check Resident #12 for a , did not use an , or start . The family member stated they viewed the emergency medical services report from with paramedics that were on scene during Resident #12's and confirmed Resident #12 had no , when the paramedics arrived to start . A review of the lunch menu, conducted on , revealed the lunch menu on consisted of cranberry glazed turkey roast or Cuban marinated Steak, cornbread , roasted parmesan brussels sprouts, and a baked roll. During an interview on at 3:31 PM the Director of Nursing stated she did not know what Staff H was doing with Resident #12's and in the video as " does not happen in the ." The Director of Nursing stated Resident #12 was not breathing from the beginning of the video as there was no rise and of Resident #12's . The Director of Nursing stated Resident #12's was open and Resident #12 never took a breath. The Director of Nursing said she did not see anyone check for a . During an interview on at 3:35 PM the Administrator stated she was not at the facility on when Resident #12 was found unresponsive. The Administrator stated she had to conduct an investigation. The Administrator stated the camera footage of the memory care dining room was not working and there was no storing of the videos during the incident timeframe. The Administrator stated the facility video system was going through an upgrade. The Administrator stated she was told Resident #12 became unresponsive in the dining room, Staff G	A 030		

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
	AL11969348	A. BUILDING: _____ B. WING _____	06/10/2026

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A 030	Continued From page 14 and Staff H took Resident #12 to her room and they called 911. The Administrator stated the staff checked Resident #12 for a , and the resident was still breathing. The Administrator stated the staff called 911 and Resident #12's daughter. The Administrator stated she was told Resident #12 was still breathing and had a , . The Administrator stated, "I would have expected the person to stay with her while the other two ran around. The Administrator said the facility did not conduct re-training on the incident because she was not made aware of the issues. The Administrator stated she was "appalled" after watching the video footage and staff needed "a lot of training." (Photographic and video evidence obtained) Class I	A 030		
A 076 SS=D	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter	A 076		

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A 076	Continued From page 15 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , staff trained in , ( ) or a health care provider	A 076		

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A 076	Continued From page 16 present in the facility, may withhold (, , , , and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain written policies and procedures governing ( ) Findings included: An attempted record review, conducted on , revealed the facility did not have written policies and procedures for ( ). During an interview on at 3:15 PM, the Administrator said there were no policies outlining the emergency response process for . Class III	A 076		