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
	AL11968227	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM OAKS ASSISTED LIVING FACILITY LLC	3610 MANASSAS AVE MELBOURNE, FL 32934

(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 #2026007957 and generator monitoring were conducted on at Platinum Oaks Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968227	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM OAKS ASSISTED LIVING FACILITY LLC	3610 MANASSAS AVE MELBOURNE, FL 32934

(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 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate daily medication observation record for each resident who receives assistance with self-administration of medications. Findings: On a review of resident #1's Medication Observation Records (MOR) revealed she had an order for (,) , 5/325mg every 4 hours for , as needed. The pharmacy label was dated for 120 tablets. There was two cards with 60 tablets each at the time of the survey. One card contained 47 tablets. Medication reconciliation was conducted with the Administrator to verify 73 doses could be verified as administered since receiving 120 tables from the pharmacy. Review of the MOR's revealed the following doses of , were documented as given to resident #1 who received assistance with self-administration of medication. , , 5 doses were documented as given on , , 6, 8, 10, and 18. , 2 doses were documented on the front of the MOR as given on and 8. Two more doses were documented on the of the MOR as effective after being given on and 25. , 1 dose was signed as given on . , - 1 dose was signed as given on . , , zero doses were documented as given.	A 054		

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
	AL11968227	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATINUM OAKS ASSISTED LIVING FACILITY LLC	3610 MANASSAS AVE MELBOURNE, FL 32934

(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 054	Continued From page 2 , 5 doses were documented as given on , , 23, 24 and 28. , 10 doses were documented as given on 1, 2, 6, 10, 15, 18, 20, 23, 26 and 29. , zero doses were documented as given. , , 1 dose was documented as given on , zero doses were documented as given. 11 doses in 2025 were documented as given. 16 doses in 2026 were documented as given. This review accounts for 27 tablets of the 73 missing tablets. On at 11:30 AM, a representative of the pharmacy verified 120 tablets of , 5/325mg were delivered to the facility on . On at 12:30 PM the Administrator was unable to provide any further documentation for the remaining 46 missing doses. (Photo Evidence obtained) Class III	A 054		