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
	AL11969688	A. BUILDING: _____ B. WING _____	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVARRE GARDENS, LLC	2640 HWY 87 SOUTH NAVARRE, FL 32566

(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 An unannounced complaint survey for allegations contained within CCR #2026002002 was conducted on 5/26/2026 at Navarre Gardens ALF At the time of the survey, deficient practice was identified.	A 000		
A 050 SS=D	429.256(2&6) FS;59A-36.008(1) FAC Medication - Self Administered Medications 429.256 (2) Residents who are capable of self-administering their own medications and performing other tasks without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. An unlicensed person may also provide assistance with other tasks specified in subsection (6). Assistance with self-administration of medication or such other tasks by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers. (6) Assistance with other tasks includes: (a) Assisting with the use of a glucometer to perform blood-glucose level checks.	A 050		

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A 050	Continued From page 1 (b) Assisting with putting on and taking off antiembolism stockings. (c) Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings. (d) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (e) Assisting with measuring vital signs. (f) Assisting with colostomy bags. 59A-36.008 Pursuant to sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule. (1) SELF ADMINISTERED MEDICATIONS. (a) Residents who are capable of self-administering their medications without assistance must be encouraged and allowed to do so. (b) If facility staff observes health changes that could reasonably be attributed to the improper self-administration of medication, staff must consult with the resident concerning any problems the resident may be experiencing in self-administering the medications. The consultation should describe the services offered by the facility that aid the resident with medication administration through the use of a pill organizer, through providing assistance with self-administration of medications, or through administering medications. The facility must contact the resident's health care provider when observable health changes occur that may be attributed to the resident's medications. The facility must document such contacts in the	A 050		

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A 050	Continued From page 2 resident's records. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the security of control substances for residents managing their own medications, (Resident#1) and centrally stored and dispensed medications The findings include: Conducted an interview on 5/26/2026 approximately 11:00 am with Resident #1. Resident #1 reported the loss of 8 to 10 hydrocodone tablets from her room, on 12/26/2025. The resident stated that, at the time the medications went missing, she did not have a key to lock her room and the facility had not instructed her to keep medication out sight, secured, or locked. The resident further stated that, after the incident, her son provided her with a lock box to secure her medications. Conducted an interview on 5/26/2026 approximately at 8:45 am with Staff A, Administrator, she stated and commented to Resident's # 1 son that resident #1 may be taking more than instructed order for Hydrocodone PRN, and for that reason she did not file a report with the police, she stated the Resident's #1 son file a report later on. Conducted an interview on 5/26/2026 approximately 9:00 am with Staff B, NP stated that she has entered orders that resident #1 could take her own pain medication. She further stated she knew Resident #1 and she never appeared sedated or impaired when she assessed her.	A 050		

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A 050	Continued From page 3 Staff B NP stated she known Resident #1, and she did not believe Resident #1 had taken more medication than prescribed. See order attached for evidence. Conducted an interview on 5/26/2026 at approximately 10:40 am with Staff #C stated the resident #1 reported missing hydrocodone tablets; however, she could not recall the exact quantity reportedly missing. She immediately notified Staff A. Conducted a record review on 5/26/2026 at 11:30 am of Resident #1. Orders revealed a note from the provider Staff B. "Patient to self-administer Hydrocodone". See attached evidence. Conducted an interview on 5/26/2026 approximately 11:10 am with Staff H, she stated she never check where Resident #1 was keeping the hydrocodone medications and she did not know when she received a box to lock the medication. Conducted an observation on 5/26/2026 at 3:00 pm with Staff B, control medication storage with the medication cart, found 2: 5 residents pop-cartridges sealed only with Scotch tape and routine nursing tape, Resident #2 and Resident #4. Discrepancies in the narcotic count on Resident #3 records. See attached photograph evidence.	A 050		