

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822		
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ZZ821	59A-35.110() FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPo rtal. 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?N o=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPo rtal.	ZZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , which is hereby incorporated by reference and available	ZZ821			

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, _____, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, _____, which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123 , and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821			

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ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to \$50 per day late not to exceed \$500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit a preliminary report within 1 business day after a resident was sent to the hospital subsequent to a for 1 of 7 sampled residents (#1), 2) failed to submit a preliminary report within 1 business day after a resident experienced a with injuries that resulted in a	ZZ821			

AHCA Form 3020-0001
STATE FORM

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ZZ821	Continued From page 5 remind her of her hair Family said they spoke with the front desk receptionist at approximately 11:55 AM on to inquire about the resident and reached out to the Resident Care Director (RCD). The family said Resident #1 was found in her room on the floor and was transferred to a hospital from the Assisted Living Facility (ALF). The family added a hospital healthcare provider recommended Resident #1 to Hospice due to the Resident's condition. The family said the resident spent 8 days at the hospital and was transferred to skilled nursing where the resident passed on During an interview on at 9:57 AM, The ARCD said Resident #1's family called and said they had not spoken to her that morning. The ARCD said she went in Resident #1's room, and she was laying on the ground in front of the bed. The resident did not seem to be injured in any way. The ARCD said Resident #1 seemed at the time. The ARCD said she did not think anything was wrong with the resident because she did not realize she was not downstairs. The ARCD said no one said Resident #1 was not downstairs and no one thought there was any concern. 2.Review of Resident #3's 1823 revealed a medical history of , and left Needed assistance with transferring. A facility progress note dated read, late entry , resident was transported to a hospital after falling in room, resident did not call for assistance until after at which time resident was reminded to call for assistance prior transferring if not stable to transfer alone.	ZZ821			

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ZZ821	Continued From page 6 During an interview on 1:11 PM, Caregiver G said pertaining to the incident, it was after 11 PM on when she was doing her rounds and found the resident in his room on the ground, near the bed. The Caregiver said Resident #3's non looked injured, seem as though it was twisted. Caregiver G added she did not remember the details exactly. The Caregiver said the Resident informed he was trying either to go on or off the bed. Review of a hospital record dated indicated Resident #1 presented with right ankle after a ground level. Resident reported he was trying to get out of his wheelchair, slipped and after twisting his ankle. Further review of the record revealed Resident #1 had an open of the right and (photographic evidence obtained) Unclassified	ZZ821			
A 000	Initial Comments A complaint investigation (2026003524) and generator monitoring was conducted at Assisted Living Facility on , and . The facility had deficiencies at the time of the visit.	A 000			
A 010 SS=D	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for	A 010			

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A 010	Continued From page 7 determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is	A 010			

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A 010	Continued From page 8 confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-	A 010			

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A 010	Continued From page 9 medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner; 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal	A 010			

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A 010	Continued From page 10 representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 7 sampled residents (#4) had a -to- medical examination by a health care practitioner at least every 3 years. Findings: Review of Resident #4's record revealed an undated incomplete 1823. During an interview on _____ at 11:15 AM, the findings were discussed with the Resident Care	A 010			

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A 010	Continued From page 11 Director (RCD). The RCD said that the facility does not have documentation for the final page of 1823 and multiple requests were sent to a health care provider to complete the 1823. Review of the documentation sent to the health care provider indicated a date of . . . and . . . There was no documentation to indicate the resident had a . . . -to- . . . medical examination that was documented in either 1823 or on the health care provider's form every 3 years thereafter. During an interview on . . . at 3:37 PM, the findings were discussed with the RCD. The RCD confirmed the findings and said Resident #4 does not have another 1823. (photographic evidence obtained) Class III	A 010			
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	A 025			

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A 025	Continued From page 12 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 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	A 025			

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A 025	Continued From page 14 hospital record revealed Resident #1 had secondary to , and elevated troponin levels. Resident was discharged to skilled nursing. Review of a termination letter revealed the resident was transported from the Assisted Living Facility to a hospital after being found down for an undetermined amount of time. Resident #1 was admitted to the hospital with a diagnosis of rhabdomyolysis, , and ended up with severe . During an interview on at 11:14 AM, Unlicensed Caregiver A said resident #1's routine each day was to go to the lobby area by the front desk and sit there all day. During an interview on at 1:29 PM, the family said regarding the incident, they were unable to contact the resident on her phone to remind her of her hair , . Family said they spoke with the front desk receptionist at approximately 11:55 AM on to inquire about the resident and reached out to the Resident Care Director (RCD). The family said Resident #1 was found in her room on the floor and was transferred to a hospital from the Assisted Living Facility (ALF). The family added a hospital healthcare provider recommended Resident #1 to Hospice due to the Resident's condition. The family said the resident spent 8 days at the hospital and was transferred to skilled nursing where the resident passed on . The family said the facility failed to provide adequate supervision which led to the residents' passing. The family said the resident had a Medicare waiver to allow her to live in the ALF because she needed assistant and was unable to live on her own, had limited mobility, and used a wheelchair.	A 025			

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A 025	Continued From page 15 During an interview on _____ at 3 PM, Caregiver D said she did not check on the resident because everything was happening so fast in the morning and at breakfast time During an interview on _____ 3:24 PM, Caregiver H, said Resident #1 never missed breakfast. During an interview on _____ 3:34 PM, the Receptionist, when she got to work at 9 AM Resident #1 would have already had her breakfast and be in the front lobby sitting in the front of the receptionist desk. The Receptionist said on _____ she did not see the resident in the lobby. The Receptionist said on _____ the daughter called the receptionist's desk in the morning and asked if she had seen the resident. Receptionist added that no one said Resident #1 was hurt or in trouble, so she did not think anything about the family's call. The Receptionist said she informed the RCD of the family's inquiry. During an interview on _____ at 3:47 PM, the Dietary Coordinator said there is a system in place, if the resident does not come to the dining room for their meal the resident will get room service. She said there is a roster where the residents will be checked off when they come to the dining room. The Dietary Coordinator said she does not have the documentation from _____. The Dietary Coordinator said after the servers will do the check off the resident, and automatically they will make a go box for the resident who does not come to the dining room and take it to their room. During an interview on _____ at 3:49 PM, the Dietary Coordinator said regarding the incident,	A 025			

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A 025	Continued From page 16 when Resident #1 does not come down she refuses to have room services. The Dietary Coordinator added that Resident #1 always came down for breakfast. The Dietary Coordinator said she was not aware that Resident #1 did not come down for breakfast on that day. The Dietary coordinator said Resident #1 will tell the servers to not bring her room service to her room. The Dietary Coordinator said when a resident refuses a meal and room service, they will document that the resident declined, however, she does not have documentation to indicate that happened. During an interview on _____ at 4 PM, the Dietary Coordinator identified the server that worked _____ and who should have brought the food tray to Resident #1. During an interview on _____ at 9:57 AM, the Assistant Resident Care Director (ARCD) regarding the incident Resident #1 did not need assistance with Activities of Daily Living (ADL's) she did everything herself. The ARCD said she did not see Resident #1 that morning prior to the incident. The ARCD said the staff do rounds when they come in but Resident #1 would say that she did not want rounds to be made and it is not necessary. ARCD said she is not sure if there is documentation of Resident #1 declining the rounds. If the resident said she does not want rounds and they refuse it we respect their rights, especially if they are independent like Resident #1 was. The ARCD said it was never known for the resident to ever miss her meals unless she goes to an _____ . If a resident does not go down to the dining room the kitchen will automatically send up the meal and the kitchen staff will deliver it to the room. The ARCD said she did not realize Resident #1 was not in the lobby because she came in at 5 AM and Resident	A 025			

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A	Continued From page 17 #1 is normally in the lobby at 8 AM. The ARCD said Resident #1's family called and said they had not spoken to her that morning. The ARCD said she went in Resident #1's room, and she was laying on the ground in front of the bed. The resident did not seem to be injured in any way. The ARCD said Resident #1 seemed . . . at the time. The ARCD said she did not think anything was wrong with the resident because she did not realize she was not downstairs. The ARCD said no one said Resident #1 was not downstairs and no one thought there was any concern. During an interview on . . . at 10:50 AM, the Dietary Server said he cannot remember the day of . . . He said usually when the residents do not come down to the dining room for their meal a server will give them room service. The Dietary Server said the meal service was starting, Resident #1 did not come down, he marked on his list as room service and brought the resident's food upstairs at approximately 10 AM. The Dietary Server said, as soon as breakfast is done, room service is started. He stated again, he does not recall the day of the incident very well. The Dietary Server said that he knew he worked that day, but he does not remember if he was responsible for bringing Resident #1's food tray to her that morning. The Dietary Server said Resident #1 was a resident that expressed that she did not like her food brought up to the room if she did not come down to the dining room. During an interview on . . . at 1:29 PM, the RCD said she received a call from Resident #1's family informing her that they were not getting in touch with her and she had a hair The RCD said at the same time around 11:15 PM, she heard on the radio, check on the	A 025			

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A 025	Continued From page 18 resident because her hair . . . was ready. The RCD said the ARCD went into Resident #1's room and informed her that Resident #1 was on the floor. The RCD said she asked the staff if they did rounds, called the kitchen to verify if the Resident came down to breakfast and did not hear from them. The RCD said the resident informed that she went downstairs and came up because she forgot something. The RCD said the ARCD informed that she did not go into the room because the resident did her medication by herself. The RCD said she watched the camera footage on and she did not see the resident leave her room and she did not go downstairs. Protocol for rounds every two hours in ALF. The RCD said if the resident does not want the staff to come in the room there is a sign that will be posted on the resident's front of their room door saying to not enter during the hours of 11PM- 7AM. The RCD said she cannot remember the resident having a sign on her door. The RCD said Resident #1 was an early riser. The RCD said the resident would voice that she did not want the staff to come into her room to disturb her and it would upset the resident if the staff went into the room, so the staff stopped going into the room. The RCD said each time the resident refused the staff to come into the room to do rounds is not documented. The RCD said she has informed the staff if they don't see a resident that they will typically see to go and check if the resident is doing ok. The RCD said she asked the staff why they did not check to see if Resident #1 went down for breakfast, and they informed her that they were busy that morning. The RCD said, usually when someone does not come down to a meal when they normally do the kitchen staff would call over the radio to see if the resident is in the building or what is going on. The RCD said that day no calls	A 025			

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A 025	Continued From page 19 were made over the radio to inquire about Resident #1 not coming to breakfast. The RCD said she does not understand how it was missed, that the resident did not come down to breakfast and that she did not leave her room. During an interview on at 2:50 PM, the Administrator said regarding the incident, the resident was an independent resident that used a motorized chair. The Administrator said if someone did not come for their meal, there is a list of residents the dietary department marks and would put if the resident came or did not come. The Administrator said whoever did not receive their breakfast the dietary staff will deliver the meal to the residents in the room. The Administrator said the cameras were checked on and no one went to Resident #1's room. The Administrator said it was mistake that the footage was not recorded. The Administrator said normally Resident #1 would sit in the lobby area with her cell phone. The Administrator added that on he does not remember seeing the resident in the lobby or anywhere else in the facility prior to her being found in her room. (photographic evidence obtained) Class II	A 025			