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
	AL11965368	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	80 NORTH CLARK RD OCOEE, FL 34761

(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 (2026009353) and generator monitoring were conducted at Madison at Ocoee on . Deficiencies were identified at the time of the survey.	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 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	A 010		

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A 010	Continued From page 1 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 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.	A 010		

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A 010	Continued From page 2 (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- 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	A 010		

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A 010	Continued From page 3 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 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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 8 sampled residents had a -to- medical examination by a health care practitioner upon development of (#1). Findings: Resident #1's health assessment form (1823), dated , documented the Resident had no On a health care provider ordered care for a on the lower area and a on the left lateral . Observations on at 2:45 PM, revealed two on the lower area that each measured approximately 1 centimeter (cm) x 1 cm and both had a white in color bed. A on the left lateral measured approximately 4 cm x 4 cm. The Resident's record did not have documentation to show the Resident had a -to- medical examination by a health care practitioner when the developed. On at 4:05 PM, the Regional Director of Wellness confirmed the findings. Class III	A 010		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living	A 028		

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A 028	Continued From page 5 (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide nail care to 2 of 11 sampled residents (#1, #9). Findings: On at 9:55 AM, caregiver A was seen putting Resident #1 in bed. The Resident's nails were long with a brown colored substance underneath them. The Resident did not verbally respond nor make contact when spoken to. When asked if the caregivers did nail care, caregiver A did not respond. A health assessment form (1823), dated , showed the Resident had a diagnosis of and needed assistance with grooming. On at 12:45 PM, the Resident's were still long with a brown colored substance underneath them. On at 2:20 PM, caregiver A said she did not do nail care on the Resident because she got busy. On at 2:25 PM, caregiver G said she did not do nail care because she did not know which residents had and she did not want to hurt someone. On at 2:30 PM, caregiver H said she did	A 028		

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A 028	Continued From page 6 not do nail care because she was afraid, she would cut the skin. Review of Resident #9's 1823 indicated the resident needed assistance with grooming. Observed on at 9:52 AM, resident laying supine in bed with untrimmed and a black substance underneath each nail. During an interview on at 10 AM, Caregiver C, said an is needed to have the resident's nails groomed and did not think the facility staff could groom her nails. During an interview on at 10:01 AM, Licensed Practical Nurse (LPN) B said that the resident is on Hospice and the resident's caregiver was at the facility today and did not do her nails. During an interview on at 10:21 AM, LPN B said that the facility staff does not groom Resident #9's nails. The LPN reviewed the resident's record and said the care staff needs to do hairstyle, grooming, and deodorant. The LPN added no one on the care staff does the Resident's nails because it is not listed as one of the items for the care staff to do. During an interview on at 10:29 AM, Caregiver C said that she learned from the Resident Care Coordinator (RCC) that the care staff can do Resident #9's nail grooming. The Caregiver said she did not groom the Resident's nails prior because she did not know that she could do it. The Caregiver added, because the resident is receiving Hospice an	A 028		

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A 028	Continued From page 7 would have needed to be made with hospice to have the resident's nails groomed. Caregiver C said last Wednesday she cleaned under the resident's nails. During an interview on at 10:49 AM, Unlicensed Caregiver E said that this past Saturday she cleaned under the resident's nails. The Unlicensed Caregiver said she does not cut the resident's nails because it was not on the list of items assigned to be completed. The Unlicensed Caregiver said she does not know if Hospice is supposed to groom the resident nails. During an interview on at 10:43 AM, Caregiver C said Hospice is not supposed to cut Resident #9's nails and she does not know who is supposed to groom her nails. (photographic evidence obtained) Class III	A 028		
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	A 054		

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A 054	Continued From page 8 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 medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a medication observation record (MOR) was updated each time a , and rate was taken for 1 of 8 sampled residents (#11.) Findings: Review of Resident #11's Health Assessment form, 1823 indicated the resident needed assistance with medication self-administration. Her medical history included , . Review of the MOR revealed , 100mg, take ½ tablet (50) mg, by twice a day with parameters to hold for less than 105 and for a .	A 054		

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A 054	Continued From page 9 Neither the MOR nor the progress notes had documentation to indicate Resident #11's , and was taken prior to the 8AM medication dose being administered on and . During an interview on at 3:42 PM, the findings were discussed with the Resident Care Coordinator (RCC). During an interview on at 4:13 PM, the RCC confirmed the findings. The RCC said Unlicensed Caregiver's took Resident #11's , and rate before administering the medication but did not document it. During an interview on at 4:38 PM, Unlicensed Caregiver E said she forgot to document the , and rate results. Unlicensed Caregiver E said that the Resident would take her , herself and she will bring the results on paper to her. The Unlicensed Caregiver said she will verify the results are in parameters and then will give the medication to the Resident. During an interview on at 4:43 PM, Unlicensed Caregiver D said she forgot to document the , and rate results. The Unlicensed Caregiver said on in the morning she took the Resident's , and rate which were ok. The Unlicensed Caregiver added that the resident would sometimes take her own , and rate, but she will always retake it to make sure it is within parameters. (photographic evidence obtained) Class III	A 054		

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A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan,	A 160		

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A 160	Continued From page 11	A 160		

with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff.
(e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C.
(f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C.
(g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C.
(h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S.
(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C.
(j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate.
(k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years.
(l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.
(m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions

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A 160	Continued From page 12 and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain a health department group care inspection. Findings: Review of facility records revealed a health department group care inspection was not available. On at 5:30 PM, the Administrator said he could not provide an inspection. Class III	A 160		