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
	AL11970185	A. BUILDING: _____ B. WING _____	09/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR OF MERRITT ISLAND	2250 N COURTENAY PKWY MERRITT ISLAND, FL 32953

(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
ZZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

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

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on review of the facility's documentation and interview, the facility failed to submit the annual Comprehensive Emergency Management Plan (CEMP) to the local emergency management agency annually as required. Findings: Review of the facility's last CEMP approval letter dated noted it expired six months ago, on . There was no documented evidence available for the annual 2026 CEMP approval letter. On at 12:45 PM, during an interview, the Maintenance Director confirmed that last year's 2025 CEMP approval letter was the only copy he had onsite. On at 6 PM, during an interview, the Administrator confirmed the finding and stated she would reach out to their generator consultant. (Photographic Evidence Obtained) Class III	ZZ830		
A 000	Initial Comments Complaint Investigation #2026014532 and Generator Monitoring survey were conducted at Hampton Manor of Merritt Island Assisted Living Facility and Memory Care with Limited Nursing	A 000		

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A 000	Continued From page 3 Services (LNS) on , and Class I deficiencies was identified for 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. The Class I noncompliance began on when the facility failed to honor resident #1's ( ) and initiated ( ). The facility could not immediately locate the resident's , initiated and called Emergency Medical Services who continued The facility's Administrator was notified by a telephone conference of the Class I noncompliance on at 10:48 AM. The census at the start of the survey was 81. The following is a description of the deficiencies found at the time of the survey.	A 000		
A 025 SS=D	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 has a change of condition , , in order to rule out the presence of an underlying physiological condition that may be contributing to	A 025		

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A 025	Continued From page 4 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 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,	A 025		

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A 025	Continued From page 5 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 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to maintain written documentation and/or facility notes for 3 of 4 sampled residents (#1, #2, #3) as required for any updates, illnesses resulting in medical attention and significant changes. Findings: 1. A review of resident #1's record revealed an admission date of . An incident occurred on at 4:50 PM, where resident #1 was found unresponsive in her room and Emergency Medical Services ( ) provided medical attention and Law Enforcement was present. Resident #1 , at 5:05 PM. There was no written facility notes documented in her file about the incident and no documentation the physician or family were notified. 2. A review of resident #2's record revealed admission date of . An incident occurred on at 8 AM, where resident #2 was found unresponsive in her living room fully dressed. Resident #2 was full code and ( ) was initiated immediately. Law Enforcement and the Emergency Medical Services ( ) rendered medical attention with unsuccessful and	A 025		

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A 025	Continued From page 6 resident #2 , , at 8:10 AM. There was no written facility notes documented in her file about this incident and no documentation that the physician or family were notified. 3. A review of resident #3's record revealed an admission date of . A Hospice interdisciplinary care plan and certification revealed resident #3 was admitted to Hospice care on , that indicated a significant change in condition. There was no written facility notes documented in his file of this significant change and no documented evidence the physician or family were notified of the significant change. On at 3:30 PM, an interview with the Wellness Director confirmed the findings. On at 6 PM, an interview with the Administrator confirmed the findings. Class III	A 025		
A 030 SS=J	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) 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	A 030		

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A 030	Continued From page 7 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 , ; 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 .	A 030		

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A 030	Continued From page 8 (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 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.	A 030		

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A 030	Continued From page 9 (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. (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	A 030		

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A 030	Continued From page 10 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 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	A 030		

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A 030	Continued From page 11 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 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	A 030		

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A 030	Continued From page 12 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 the interview, and record review, the facility failed to honor resident rights as required for 1 of 4 sampled residents found unresponsive, (#1). This failure resulted in initiation of , , ( ) against the resident's wishes and executed ( ). Findings: An incident reported by the facility on at 4:50 PM, noted that , Resident #1, had a and was found unresponsive in her room. The report indicated was initiated by staff at the facility until Emergency Medical Services ( ) arrived and after unsuccessful attempts, Resident #1 was pronounced at 5:05 PM. Review of Resident #1's record revealed she was admitted to the facility on . The last 1823 Health Assessment form dated listed a medical history of , , (irregular rhythm), and , , . The form indicated resident #1 ambulated with a walker, needed assistance to self administer her medication, and needed supervision with activities of daily living (ADLs), including ambulation, bathing and . The resident's record detailed that resident #1 had a dated .	A 030		

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A 030	Continued From page 13 A review of the facility's policy updated on noted were to be respected, honored where lawful and integrated into emergency response procedures in compliance with the Florida law, Agency for Healthcare Administration (AHCA) rules and resident rights. The facility's procedures documented that did not directly mean withhold all emergency care, only performance of in the event of . The facility's policy and procedures did not indicate resident 's were located on the of the resident's doors to let all staff know not to perform , this was instructed verbally during the 1-hour in-service training conducted by the Wellness Director and Administrator. On at 3:00 PM, in a telephone interview, Medication Technician (Med Tech) A said she went to Resident #1's room to ask the resident for her dinner order. She recalled when she entered the room, Resident #1 was slumped over in her bed to the left side. She said the resident's body was still warm to touch but her , were blue. Med Tech A explained she immediately checked on the of the apartment door for Resident #1's , and there was no order there. She stated all 's were located on the of the resident's room door. Med Tech A said she called on the radio STAT and began on Resident #1. She indicated she continued until Licensed Practical Nurse (LPN) B came to the room and took over doing . Med Tech A explained from the time she and LPN B placed Resident #1 on the floor, the total time of performed was approximately two minutes. She stated at that time, and Law Enforcement had arrived at the resident's room. Med Tech A revealed that later that evening Resident #1's	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970185	A. BUILDING: _____ B. WING _____	09/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR OF MERRITT ISLAND	2250 N COURTENAY PKWY MERRITT ISLAND, FL 32953

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A 030	Continued From page 14 form was found in her kitchen cupboard. She said they did not know who placed the form in the kitchen cupboard instead of on the of the door per facility procedure. On at 7:04 PM, in a telephone interview, LPN B confirmed she heard radio STAT called from Med Tech A and within seconds she went to Resident #1's room along with Med Tech C and Med Tech D to assist. LPN B said she took over performing from Med Tech A until arrived at the facility. She recalled the personnel called Resident #1's time of at 5:05 PM. LPN B noted the total time she and Med Tech A performed was approximately two minutes. On at 4:15 PM, the Front Desk Concierge E confirmed she worked on . She stated she took the and sheet from the facility's red book in the front office to Resident #1's room. She said she gave them to Med Tech A and LPN B at about 4:52 PM after hearing Med Tech A calling STAT on the radio. She stated she accompanied law enforcement officers and personnel that had arrived at the facility in response to a 911 call to resident #1's room. On at 9:22 AM, the Wellness Director stated she received a phone call from LPN B at 4:59 PM, about the event, and she arrived at the facility at approximately 5:15 PM. The Wellness Director said she notified the family of Resident #1 at 5:07 PM after EMT recorded a time of at 5:05 PM. She stated she instructed all staff involved in the incident to write witness statements. On at 10:27 AM, Med Tech C stated she saw the resident earlier in the afternoon. She	A 030		

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A 030	Continued From page 15 remembered she heard the STAT call at about 4:55 PM, from Med Tech A and immediately went to the resident's room to assist. She said she saw LPN B and Med Tech D were in the room performing . Med Tech C said she assisted with the by holding the resident's down as they were moving upward involuntarily from the pressure. She recalled Med Tech D called 911. She said it was a few minutes until arrived and took over from LPN B until they called the time of at 5:05 PM. A review of personnel records verified Med Tech A, and LPN B completed their one-hour in-service training. Interviews on and with Med Tech A, LPN B, Med Tech C, and Med Tech D revealed they all confirmed they received verbal instruction that for each resident were located on the of the room door to easily identify what the resident's wishes were regarding . A review of the in-service training revealed specific to the facility's policy and procedures (updated) all did not direct withholding of services for all emergencies, but only pertaining to in the event of . The training included the policy that all 's were to be respected and honored according to the Florida Law, AHCA rules and resident's rights. Review of the facility's record revealed they did not conduct a thorough investigation into this event. There were not any written facility notes relevant to this significant event. The facility staff involved could not provide any exact times for the incident as they did not document the time in their individual written witness statements. Furthermore, there was no documented evidence	A 030		

Agency for Health Care Administration

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A 030	Continued From page 16 the physician and family were notified of Resident #1 regarding the event. On at 6:00 PM, the Administrator and the Wellness Director confirmed the findings. On at 10:48 AM, a formal telephone exit interview with the Administrator confirmed the findings. (Photographic Evidence Obtained) Class I	A 030		