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
	AL11968349	A. BUILDING: _____ B. WING _____	C 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTO TAVARES	1761 NIGHTINGALE LN TAVARES, FL 32778

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A 000	Initial Comments A complaint investigation (complaint number 2026014266) was conducted at Alto Tavares on August 25, 2026. Deficiencies were identified at the time of the visit.	A 000		
A 025	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 dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. 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 appointments 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	A 025		

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A 025	Continued From page 1 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 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate supervision to meet the needs of residents accepted for admission to the facility for 1 of 3 residents reviewed for falls (Resident #1). Findings include: Review of Resident #1's record revealed he was admitted to the facility on 07/18/24 with a diagnosis that includes Seizer Disorder, Hypothyroidism and Hyperlipidemia. Resident #1's Health Assessment dated 06/16/26 read, resident requires supervision with ambulation, bathing, dressing, toileting, and transferring.	A 025		

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A 025	Continued From page 2 Review of Resident #1's incident report dated 08/04/26 at 07:15 AM revealed resident had an unwitnessed fall with injury. The incident report read, " Resident was laying on the floor in front of his sink. His shower chair was knocked over and there was blood located all throughout the bathroom." Apparent injuries: hit head, laceration, pain, and shoulder Pain. Review of Resident #1's Hospital Discharge Summary dated 08/07/26 read, " [Resident #1's name, age, and diagnoses] was admitted following a fall at his assisted living facility, during which he remained on the floor for three days prior to presentation;" "During the admission, he was also managed for systemic inflammatory response syndrome (SIRS) and non-traumatic rhabdomyolysis, likely related to prolonged immobility, with CK [Creatine Kinase] levels peaking above 10,000 and acute kidney injury superimposed on chronic kidney disease." Review of Resident #1's progress note dated 08/05/26 read, "The med tech [Medication Technician] assigned to this Resident on Sunday and Monday before his fall stated that she saw him downstairs talking with another Resident on Sun [Sunday] 08/02/26 and on Mon [Monday] 08/03/26 saw him taking out his trash, but does not think he came down for meals." During an interview on 08/25/26 at 03:07 PM, Staff A, Medication Technician stated, "When a resident misses a meal, staff go check on the resident if they're not already downstairs to see why they didn't come down, or kitchen staff will notify care staff [that resident did not come down to a meal]. I am unsure if Resident #1 came to the dining room for all meals on 08/03/26. I had	A 025		

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A 025	Continued From page 3 already laid eyes on him that morning, so I didn't go check on him in his room for the rest of the day because he doesn't receive medications from the medication cart." Review of the facility's policy and procedure titled "Daily Safety Check, Meal Time & Medication Time Observation Policy" dated 12/06/23 read, "Any associate who recognizes that an Assisted Living or Ensemble Care resident is not present during scheduled meal times and medication times will report this information to a nurse on duty or a manager within a reasonable period of time, who will confirm the resident's whereabouts. The results of the search will be documented in the resident record by a licensed nurse of Medication Assistant Care Staff associate." During an interview on 08/25/26 at 03:30 PM, the Administrator confirmed that kitchen staff did not document Resident #1's attendance at meals on 08/03/26 as required. He stated that there were no meal tickets with the resident's name on them from 08/01/26 to 08/03/26. During an interview on 08/25/26 at 04:06 PM, the Resident Services Director stated, " Dietary staff should have documented resident attendance at meals as they're supposed to, so the nursing staff would know to check on a resident that didn't make it to lunch or dinner. She confirmed that there was no documentation that dietary filled out the required form. She explained that because they didn't do that, they could've missed checking on Resident #1 a second time on 08/03/26. Class II	A 025		

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A 030	Continued From page 4	A 030		
A 030	59A-36.007(5) FAC; 429.28(1-2) 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 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; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE 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	A 030		

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A 030	Continued From page 5 facility's policies regarding: 1. Resident responsibilities; 2. Alcohol and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident abuse, neglect, and exploitation; 6. Administrative and housekeeping schedules and requirements; 7. Infection 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 restraints. (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	A 030		

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A 030	Continued From page 6 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 abuse 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. (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	A 030		

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A 030	Continued From page 7 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 appointments for health care services, the provision of or arrangement of transportation to health care appointments, and the performance of health care services in accordance with s. 429.255 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 incapacitated, 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.	A 030		

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A 030	Continued From page 8 (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, 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, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or 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 Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability 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 Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida.	A 030		

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A 030	Continued From page 9 429.27 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 incompetent or incapacitated 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 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 observation, interview, and record review, the facility failed to ensure 1 of 3 residents sampled (Resident #1) live in a safe and decent living environment by failing to follow facility policy and procedures to prevent falls. Findings include: Review of Resident #1's record revealed he was admitted to the facility on 07/18/24 with a diagnosis that includes Seizer Disorder, Hypothyroidism and Hyperlipidemia. The Health Assessment dated 06/16/26 read, resident requires supervision with ambulation and transferring. Record revealed the last Fall Risk Evaluation was completed on 07/14/26.	A 030		

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A 030	Continued From page 10 Review of Resident #1's incident report dated 08/04/26 at 07:15 AM revealed resident had an unwitnessed fall with injury. The incident report read, "Resident Follow Up and Prevention: Fall Reduction Interventions Implemented; Non-skid mats in shower, pendant on resident." During an observation on 08/25/26 at 02:54 PM, Resident #1's shower was observed to have 11 thin non-slip strips applied to the surface of the floor, but there was no non-skid mats observed in shower. During an interview on 08/25/26 at 04:06 PM, the Resident Services Director (RSD) stated, " One of the nurses had asked Resident #1's family to provide a non-slip mat for the shower, but there is no note to indicate that they were waiting on the family. She also stated, " The fall risk evaluation should've been done when he [Resident #1] got back." Review of the facility's policy and procedure titled "Minimizing Fall Risk" dated 08/03/18 read, " When a fall occurs, the RSD or ARSD will evaluate the resident using the Fall Risk Evaluation Form within seventy-two (72) hours. The RSD or ARSD must then review current interventions or implement new interventions within 72 hours based on that evaluation." Class III	A 030		