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
	AL11969905	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDISON OF OVIEDO (THE)	1915 W COUNTY RD 419 CHULUOTA, FL 32766

(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
ZZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ␣ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣ , to the Federal Bureau of Investigation for a national criminal history record check. The ␣ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣ , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	ZZ816		

AHCA Form 3020-0001

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

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ZZ816	Continued From page 1 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any	ZZ816		

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ZZ816	Continued From page 2 disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure the personnel record for 2 of 5 sampled staff (A, C) contained a complete attestation of compliance with background screening requirements. Findings:	ZZ816		

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ZZ816	Continued From page 3 1. Review of Staff A's personnel record revealed a hire date of . The record contained a signed attestation. The health care provider/ employer's name and address were not completed. During an interview on at 1:33 PM, the findings were discussed with the Administrator. The Administrator said there is no other attestation for the employee. 2. Review of Staff C's personnel record revealed a hire date of . The record contained a signed attestation. The health care provider/ employer's name and address were not completed. During an interview on at 1:51 PM, the findings were discussed with the Administrator. The Administrator said that she does not have any other attestation with the complete information. (photographic evidence obtained) Unclassified	ZZ816		
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	ZZ821		

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ZZ821	Continued From page 4 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/SingleSignOnPortal: 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?No=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/SingleSignOnPortal. 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?N	ZZ821		

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ZZ821	Continued From page 5 o=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 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	ZZ821		

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ZZ821	Continued From page 6	ZZ821		

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:

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.

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ZZ821	Continued From page 7 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 interview and record review, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days of 1 of 5 sampled residents' elopement (#14) and was at risk of harm. Findings: A health assessment form (1823), dated , documented a medical history of . The form documented "no" to elopement risk but that the Resident benefited from a memory care locked unit for safety. A facility note, dated at 10:10 PM, documented the Resident moved into this facility around 3:30 PM. The note showed that after 45	ZZ821		

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minutes she became agitated, looking for her parents, went on the porch, and refused medication.

A facility note, dated at 11:25 PM, documented the Resident had times when she forgot where she was and wanted her mom and dad. The note showed the Resident was exit-seeking.

A facility note, dated at 2:21 AM, documented the Resident was very and exit seeking. The note showed the Resident looking for her husband and moving personal items from her room to another Resident's room.

A facility note, dated at 1:10 PM, documented the Resident packing her belongings and moved them out of her room. The note showed the Resident exit-seeking and wanted to call law enforcement.

On at 4 PM, caregiver B said the Resident was an exit-seeker and packed her belongings often. The caregiver said that shortly after moving in on , the Resident was missing one night at about 9 PM.

On at 5:54 PM, caregiver L said that sometime prior to the elopement, she was at the facility when caregiver N called her around 9 PM and said the Resident got out of memory care and went out a side door to the parking lot. The caregiver said the Resident frequently pushed on doors and packed her belongings. The caregiver said the Resident was redirected with little success, became agitated, and frequently at night.

On at 4:28 PM, caregiver N said that

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sometime prior to the elopement, the Resident was found to be missing at around 9 PM. The caregiver said that when she opened the door to the parking lot the Resident was standing just outside the door.

A facility note, dated at 3:35 PM, showed the Resident loosened the window restrictor, opened the window, broke through the screen, and exited through the window. She then closed the window behind her. She was then met in the parking lot by a caregiver and was promptly brought inside.

On at 4:19 PM, caregiver M said that on at about 2:40 PM she arrived for her shift and saw the Resident standing bent over next to the stop sign near the employee parking area. The caregiver said she walked with and guided the Resident to the front entrance, where she was met by caregiver A and they returned the Resident to memory care. Caregiver M said the Resident always wanted to leave and go with her husband.

On at 11 AM, caregiver A said that when the Resident was found in the parking lot, she had her books in a book bag, and she was angry and crying. The caregiver said that prior to the elopement, the Resident would look for and wait for her family. The caregiver said the Resident would go to the door but would not push it or follow people out of memory care. The caregiver said the Resident would be up during the night, wanting to leave.

On at 12 PM, the Maintenance Director said that on the Resident broke one of the plastic clips and somehow removed the other one which allowed her to fully open her bedroom

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ZZ821	Continued From page 10 window, push the screen out, and climb out. On at 5:20 PM, the Administrator said she was told the Resident only got out of memory care during the first elopement and not outside the facility. The Administrator could not remember the date of the first incident. She said the preliminary and full reports were not submitted when the Resident eloped because the Resident did not leave the property. The facility's missing resident policy, dated , , did not define elopement. Unclassified	ZZ821		
ZZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person	ZZ841		

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responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor.
(b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care.
(c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects:
1. End-of-life situations.
2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support.
3. The resident, client, or patient is making one or more major medical decisions.
4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently .
5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
6. A resident, client, or patient who used to talk

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and interact with others is seldom speaking.
7. For hospitals, childbirth, including labor and delivery.
8. patients.
(d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures.
(e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request.
(f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (# 11) who received hospice services had documentation in their file of an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility.

Findings:

Review of resident # 11's record revealed the resident was admitted to hospice at the facility on .

The record did not have an interdisciplinary care plan that included services being provided by

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ZZ841	Continued From page 13 hospice and those being provided by the facility. On at 3:30 PM the findings were confirmed by the Wellness Director. Class III	ZZ841		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the	ZZ875		

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ZZ875	Continued From page 14	ZZ875		

employee, provide the employee with a copy of the record of completion consistent with the employer's written policies.
3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider.
(c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with . 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or

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ZZ875	Continued From page 15 participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d),	ZZ875		

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or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request.
2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.
(7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant.
(8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board.
(9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6).

This Statute or Rule is not met as evidenced by:
Based on personnel record review and interview, the facility failed to ensure 1 of 5 sampled staff (O) completed a 1-hour training on 's and related forms of (ADRD) provided by the department of elderly affairs

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ZZ875	Continued From page 17 within 30 days after beginning employment. Findings: Review of the Limited Nursing Services Registered Nurse (LNS RN) O's personnel record revealed a hire date of . The record did not contain evidence to indicate she completed a 1-hour training on ADRD provided by the department of elderly affairs within 30 days after beginning employment. During an interview on at 4:12 PM, the findings were discussed with the Administrator. During an interview on at 6:30 PM, the Administrator said that corporate was pulling the training. No additional information was received. Class III	ZZ875		
A 000	Initial Comments A re-licensure survey with Limited Nursing Service (LNS) and a generator monitoring were conducted at The Addison of Oviedo 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	A 010		

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A 010	Continued From page 18 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 19 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 20 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 21 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 interview and record review, the facility failed to ensure 1 of 5 sampled residents (# 11) who received hospice services had documentation in their file of an interdisciplinary care plan that specifies the services being provided by the facility and those being provided by the facility. Findings: Review of resident # 11's record revealed the resident was admitted to hospice at the facility on	A 010		

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A 010	Continued From page 22 The record did not have an interdisciplinary care plan that included services being provided by hospice and those being provided by the facility. On at 3:30 PM the findings were confirmed by the Wellness Director. 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 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	A 025		

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A 025	Continued From page 23 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 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision when 1 of 5 sampled residents (#14) who eloped twice from the memory care unit and failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for	A 025		

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A 025	Continued From page 24 with injuries for 1 of 5 sampled residents (#5). Findings: 1. On at 1:42 PM, Resident #14's power of attorney (POA) said that prior to moving into this facility, the Resident lived in independent living at another community. The POA explained that the Resident tried to leave the other community and had increased , , so she was moved to this facility. On at 2:15 PM, the Administrator confirmed the Resident previously lived independently at another community where she began exit-seeking and was transferred to this facility's secure memory care. On , a health care provider documented that the Resident had progressive and had an elopement event while living independently at the other community. A health assessment form (1823), dated , documented a medical history of . The form documented "no" to elopement risk but that the Resident benefited from a memory care locked unit for safety. A facility note, dated at 10:10 PM, documented the Resident moved into this facility around 3:30 PM. The note showed that after 45 minutes she became agitated, looking for her parents, went on the porch, and refused medication. A facility note, dated at 11:25 PM, documented the Resident had times when she forgot where she was and wanted her mom and	A 025		

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A 025	Continued From page 25 dad. The note showed the Resident was exit-seeking. A facility note, dated at 2:21 AM, documented the Resident was very and exit seeking. The note showed the Resident looking for her husband and moving personal items from her room to another Resident's room. A facility note, dated at 1:10 PM, documented the Resident packing her belongings and moved them out of her room. The note showed the Resident exit-seeking and wanted to call law enforcement. A facility note, dated at 3:35 PM, showed the Resident loosened the window restrictor, opened the window, broke through the screen, and exited through the window. She then closed the window behind her. She was then met in the parking lot by a caregiver and was promptly brought inside. On at 4:19 PM, caregiver M said that on at about 2:40 PM she arrived for her shift and saw the Resident standing bent over next to the stop sign near the employee parking area. The caregiver said she walked with and guided the Resident to the front entrance, where she was met by caregiver A and they returned the Resident to memory care. Caregiver M said the Resident always wanted to leave and go with her husband. On at 11 AM, caregiver A said that when the Resident was found in the parking lot, she had her books in a book bag, and she was angry and crying. The caregiver said that prior to the elopement, the Resident would look for and wait for her family. The caregiver said the Resident	A 025		

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A 025	Continued From page 26	A 025		

would go to the door but would not push it or follow people out of memory care. The caregiver said the Resident would be up during the night, wanting to leave.

On at 11:45 AM, caregiver H said that on at about 1:30 PM, she saw the Resident in the dining room. The caregiver explained that at about 2 PM, she did not see the Resident and began asking other staff if they saw her. The caregiver said the Resident was an exit-seeker, did not want to be here, and oftentimes looked for her husband.
On at 12 PM, the Maintenance Director said that on the Resident broke one of the plastic clips and somehow removed the other one which allowed her to fully open her bedroom window, push the screen out, and climb out.

On at 4:08 PM, caregiver K said she last saw the Resident on at about 12 PM eating lunch in the dining room. The caregiver said the Resident always said she had to get out and go home.

On at 11:32 AM, caregiver G said the Resident went from one extreme to another when it came to her being upset, not liking her roommate, and being here. The caregiver said that at times the Resident asked staff to open the door and let her out.

On at 11:52 AM, the Memory Care Director said the Resident would ask staff to let her leave because she wanted to go home.

On at 4 PM, caregiver B said the Resident was an exit-seeker and packed her belongings often. The caregiver said that shortly after moving in on , and before the

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(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 025	Continued From page 27 elopement, the Resident was missing one night at about 9 PM. The caregiver said the Resident followed caregiver L out of memory care and was later found in the parking lot by caregiver N. On at 5:54 PM, caregiver L said that sometime prior to the elopement, she was at the facility when caregiver N called her around 9 PM and said the Resident got out of memory care and went out a side door to the parking lot. Caregiver L denied that the Resident followed her out of memory care. The caregiver said the Resident frequently pushed on doors and packed her belongings. The caregiver said the Resident was redirected with little success, became agitated, and frequently at night. On at 4:28 PM, caregiver N said that sometime prior to the elopement, the Resident was found to be missing at around 9 PM. The caregiver said that when she opened the door to the parking lot the Resident was standing just outside the door. On at 5:20 PM, the Administrator said she was told the Resident only got out of memory care during the first elopement and not outside the facility. The Administrator could not remember the date of the first incident and said it was not documented. The facility's missing resident policy, dated , documented that a new elopement risk assessment would be completed when the resident was returned. On at 1:25 PM, the Wellness Director said no additional elopement assessments were	A 025		

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	AL11969905	A. BUILDING: _____ B. WING _____	09/10/2026

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A 025	Continued From page 28 completed. 2. On at 9:50 AM, Caregiver C stated during the staff interview that Resident #5 a lot. Further stating, the resident had a bad about 2 -3 weeks ago which required her to go to the hospital. On at 10:15 AM, Resident #5 was observed in her apartment laying on her sofa. Resident, attempting to sit up appeared disoriented, reaching for the walker, and continuing to stand. She stated she was fine and did not need a nurse. The resident was asked about the on . She said that was her first . Adding, she does not need assistance when getting up and just forgot to get her walker. Review of Resident #5's record revealed a facility admission date on . The 1823 health assessment indicated a medical history of , difficulty in walking, lack of coordination, , communication , abnormal posture, and unspecified . Her activities of daily living revealed needs supervision for ambulation, bathing, , toileting, and transferring. Review of an Incident Report dated indicated any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident. Resident transferred to the hospital. The narrative states on at approximately 4:00 PM, Resident #5 experienced an unwitnessed in her bathroom in her apartment. She had a to the left side of her forehead. She was sent to the hospital for evaluation and was treated with to the left side of her	A 025		

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A 025	Continued From page 29 forehead. Resident #5 remained at the hospital overnight for observation and will either return to the community on . . or go to a SNF (skilled nursing facility) for rehabilitation. The facility's Management Handbook Health Related Services Manual dated states this Community's policy is to enhance each Resident's mobility and encourage independence by minimizing the risk of when possible and reducing both the incidence of and the injuries that may accompany . Residents identified as at risk for should have a Negotiated Risk Assessment (NRA). An NRA should be utilized if the Resident has a significant history, previous significant injuries from falling or such as that places them at higher risk for injury from . A facility note on at 1:39 PM, resident discussed during IDT meeting due to recent readmission after hospitalization and rehab facility stay. The resident returned with orders for , , services. The resident will be receiving frequent sitters by family to decrease risk of . A facility note on at 2:04 PM, resident voiced no c/o , or discomfort. A facility note on at 10:00 PM, resident has been ambulating with a walker. A facility note on at 5:27 AM, resident slept through the night, no c/o , or discomfort. A facility note on at 11:37 AM, resident assistant ( ) assisted with , this am, voiced no c/o , or discomfort. A facility note on at 3:38 PM, resident	A 025		

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A 025	Continued From page 30 returned from rehab with a family member ambulating with her walker. Alert skin warm and dry to touch, noted suture site scabbed over no drainage stated they removed the a couple of days ago, faded ˘ to forehead and , ˘ faded on right , continues to have the raised , areas on right . A facility note on at 10:32 PM, resident has no c/o , or discomfort. Resident gait is steady with walker. A facility note on at 3:54 PM, case manager from rehab called to let this writer know that residents last covered day is this Saturday and she will need to be to the facility on Sunday. A facility note on at 3:29 PM, the hospital called to inform her that resident is going to SNF for rehab as she needs , , for strength and endurance. A facility note on at 4:56 PM, resident was found on the floor of her bathroom, ˘ profusely and has a lac on the L side of the forehead. Resident stating she was attempting to turn around. Resident had taken off pendant and had no walker which were both left in the bedroom. Resident has been sent to the hospital. A facility note on at 10:50 PM, resident was found on the floor. Resident stated she was eating her ice cream when she dropped her spoon and was trying to turn around to pick it up off the floor and she got on her and couldn't get up. A facility note on at 3:33 PM, the	A 025		

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A 025	Continued From page 31 called for writer to come to resident's room. Observed resident lying on the floor with her right arm against the shelf in her room. Resident stated she when she was turning and noted her walker was next to her sink. The resident stated she didn't hit her and was able to move all extremities. On at 2:43 PM, LPN J stated she did not witness the but was called to the room as she was the nurse in the building. She stated the resident gets up, forgets she does not have her walker, and starts messing with stuff. Further stating, the resident has 's and her family says it's normal that she all the time. A facility note on at 10:17 PM, resident has a noticeable large bump on the L , resident states it's not painful but it is discolored. A facility note on at 7:16 AM, resident was found on the floor by her bed, she trying to get up to use the bathroom, it happened around 5AM. A facility note on at 6:16 PM, asked writer to look at residents' Lt . A facility note on at 12:28 PM, resident last evening. Resident was found on her on the closet floor in a puddle of . Resident was w/o injury and was assisted up from floor and cleaned up. Daughter is taking the resident to urgent care for possible . A facility note on at 10:41 PM, Caregiver I went in to check on resident, found her lying on the floor in her closet, and called for writer. Arrived at resident room, observed resident lying on the floor in her closet with no pull up on and	A 025		

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A 025	Continued From page 32 was of on the floor. Resident denies hitting her or , , noted redness to left side of and right upper side of . On at 2:15 PM, Caregiver I was observed assisting and escorting Resident #5 to the common area for an activity. On at 2:30 PM, Caregiver I stated she was not working during any and did not assist the resident. A facility note on at 2:02 AM, care staff found the resident on the bathroom floor. Resident stated she was walking to the bathroom floor and lost her balance. On at 3:45 PM, Caregiver B stated she has provided assistance and care to the resident. Caregiver B explained that she did find the resident on the floor during on . She said she does not remind the resident to use her pendant because she knows she's supposed to. Adding, the resident does not call for help until after she has . On at 2:31 PM, the Care Coordinator stated she's responsible for the residents who , responsible for their care plan, and checking every two hours. Adding, since Resident #5 returned from rehab they keep her out of the room as much as possible, getting her involved in activities. She said the family stated that's normal for her, daily . Further stating, the facility learned after Resident #5 moved in that she was a risk. The Care Coordinator was asked how often the sitters were coming. She said she was not aware that was happening and had not seen anyone coming to the facility. Adding, the family posted a notice on Facebook asking for a	A 025		

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A 025	Continued From page 33 Vietnamese speaking sitter, but no one has come to sit with her yet. Review of the Risk Assessment Tool indicates a score of 4 or more is considered at risk for falling. Resident #5's 6 reports completed by the Wellness Director revealed the following dates and total scores: Total 8, Total 9, Total 9, . Total 9, ... Total 8, and Total 9. All scores were greater than 4. The Resident Care Summary indicates management (risk) - remind resident to keep walker next to her at all times, - resident reminded to use call pendant for assistance, - reminder to wear nonskid socks, - resident to participate with activities, to assist with decreasing room time, - request to family for possible / . Review of the Service Plan for Resident #5 indicated . . . -reminders / prepare items / standby assistance, assistance with morning , assistance with bedtime ; toileting - reminders /standby assistance, and transfer- cueing / reminders / supervision. The plan summary for risk reflected as moderate identified as risk - NRA required. On at 4:43 PM, the Wellness Director stated they do not have an NRA for Resident #5. After reviewing the management policy, the Administrator stated they did not need to provide an NRA for the resident as she was compliant. The Administrator was made aware the Service Plan indicated NRA required and the Management Policy on page 2 states the NRA should be utilized if the resident has a significant	A 025		

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A 025	Continued From page 34 history. Resident #5 has a total of 7 since her admission to the facility and a which places her at a higher risk for . The Wellness Director and Administrator were asked about the frequent sitters and how often they were coming. On at 5:12 PM, the Wellness Director stated it's not actual sitters but different family members who were coming to visit. Further stating, after each there are inventions, but the resident is resistant to receiving care from the staff. The Administrator stated the family has been coming at different times. She was asked to provide a printout of the sign in and out log to verify but no documentation was provided before the exit. On at 5:48 PM, LPN L stated she was called to the room during the on and observed the resident on the floor with coming from her . She said she does frequent reminders and frequent checks, reminding the resident to use her pendant and to call for help. LPN L said Resident #5 does not use her pendant and is not , to remember. Adding, if she could remember she would call and there would be less . On at 6:40 PM, the POA (power of attorney) stated he believes the facility is doing everything to keep Resident #5 safe, but she refuses to use the pendant. He stated his wife is handling the setting up for the sitter, but no one has started yet. He added he will not have someone from outside coming in. No further explanation provided. He said he works at night and visits as often as possible. The POA stated the resident had a lot of at home and that is	A 025		

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A 025	Continued From page 35 why he put her in a facility as they could no longer take care of her. He said her are due to the 's . On at 7:00 PM, the Administrator and Wellness Director confirmed the findings. (photographic evidence obtained) Class II	A 025		
A 040 SS=D	429.55(2) F.S. Resident Education- (V (2) VTE CONSUMER INFORMATION.- (a) The Legislature finds that many (PEs) are preventable and that information about the prevalence of the could save lives. (b) The term ", " means a condition in which part of the clot breaks off and travels to the , possibly causing . (c) The term " " means , which is a clot located in a deep , usually in the or arm. The term can be used to refer to , , , or both. (d) Assisted living facilities must provide a consumer information pamphlet to residents upon admission. The pamphlet must contain information about , including risk factors and how residents can recognize the signs and symptoms of . This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to provide a consumer information pamphlet about ,	A 040		

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A 040	Continued From page 36 including risk factors and how residents can recognize the signs and symptoms of to 2 of 5 sampled residents upon admission (#5, #11). Findings: Review of Resident #5's record revealed a facility admission date on . There was no documented evidence the facility provided the pamphlet pertaining to . On at approximately 3:50 PM, the Administrator provided a purple folder enclosed with a document about which included a handwritten date of . On at 6:30 PM, the Administrator stated she did not have any signed evidence that Resident #5's family received the actual pamphlet. A review of Resident #11's record revealed the date of admission as . There was no documented evidence provided by the facility that the resident and/or legal representatives received the consumer education pamphlet upon admission. On at 6:29 PM the Administrator confirmed the finding. Class III	A 040		

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A 052	Continued From page 37	A 052		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit	A 052		

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A 052	Continued From page 38 dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.	A 052		

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A 052	Continued From page 39 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,	A 052		

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A 052	Continued From page 40 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to report medication refusals to a health care provider for 1 of 5 sampled residents (#14). Findings: Review of Resident #14's medication observation record revealed documentation that showed the Resident refused her medications on , , , , , and . The MOR nor the Resident's record had	A 052		

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A 052	Continued From page 41 documentation to show the refusals were reported to a health care provider. On at 1:06 PM, the findings were discussed with the Wellness Director. Class III	A 052		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not	A 078		

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	AL11969905	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 078	Continued From page 42 constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility ␣ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure 4 of 5 sampled staff (Administrator, A, B, C) submitted a written statement from a health care provider	A 078		

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A 078	Continued From page 43 documenting that the individual did not have any signs or symptoms of communicable within 30 days after beginning employment, and failed to ensure evidence of a negative ( ) examination was documented on an annual basis for 1 of 5 sampled staff (O.) Findings: 1.Review of Unlicensed Caregiver A's personnel record revealed a hire date of . The record did not contain a written statement from a health care provider documenting the Unlicensed Caregiver did not have any signs or symptoms of communicable . During an interview on at 1:34 PM, the findings were discussed with the Administrator. During an interview on at 1:50 PM, the Administrator said she did not have the one time free of communicable statement. 2.Review of Caregiver C's personnel record revealed a hire date of . The record did not contain a written statement from a health care provider documenting the Caregiver did not have any signs or symptoms of communicable . During an interview on at 2:50 PM, the findings were discussed with the Administrator. The Administrator said that she does not have the communicable statement she only had the . 3.Review of the Limited Nursing Services Registered Nurse (LNS RN) O's personnel record revealed a hire date of . The record contained a , results indicating the LNS RN was free of communicable	A 078		

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A 078	Continued From page 44 and . The record did not have documentation of a negative exam annually thereafter. During an interview on at 5:13 PM, findings were discussed with the Administrator. The Administrator said that LNS RN O does , and all she had was the results dated . 4. Review of Unlicensed Caregiver B's employee record revealed a hire date of . The record did not include a written statement from a healthcare provider documenting that Unlicensed Caregiver B did not have any signs or symptoms of communicable within 30 days after beginning employment. On at 6:04 PM the Administrator confirmed the finding. 5. Review of the Administrator's personnel record revealed a hire date of . The record did not have a written statement from a health care provider documenting that the Administrator does not have any signs or symptoms of communicable . On at 6 PM, the Administrator said she did not have the written statement. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee	A 081		

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A 081	Continued From page 45 who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice	A 081		

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A 081	Continued From page 46 orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:	A 081		

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A 081	Continued From page 47 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

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A 081	Continued From page 48 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 2 of 5 sampled staff (A and B) who provided direct care to residents received the required minimum of one hour of in-service training in control using the facility's control policies and procedures. Findings: 1. Review of Unlicensed Caregiver B's employee record revealed a hire date of . The one-hour control certificate did not indicate the training was conducted using the facility's policies and procedures. On at 6:04 PM the Administrator confirmed the finding. 2. Review of Unlicensed Caregiver A's personnel record revealed a hire date of . The record included a 0.25-hour control basic training, a 15 minutes control basic concepts training, a 1-hour about control and prevention training and a 1-hour about control and prevention training. The record revealed the training courses were online based training courses and there was no documentation to indicate either of the trainings addressed the facility's sanitation procedures using the facility's control policies and procedures. During an interview on at 1:33 PM, the	A 081		

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A 081	Continued From page 49 findings were discussed with the Administrator. During an interview on at 1:48 PM, the Administrator said Staff A received facility policies and procedures training for control during the 2-hour pre-service orientation. Review of the 2-hour pre-service orientation dated revealed the training covered facility policies and procedures. The pre-service orientation did not have documentation to indicate that control was included in the training. During an interview on at 1:49 PM, the findings were discussed with the Administrator, who confirmed the findings. During an interview on at 4:05 PM, the Administrator said to her understanding the facility's control policy is incorporated in the online based control and prevention policy. Review of Unlicensed Caregiver A's online based control course completion summary revealed the control organization specific policy and procedure training had a zero for the duration of time. During an interview on at 5:58 PM, the findings were discussed with the Administrator. The Administrator said that a facility certificate was not created for the control training because the training was done on the online based training with the facility specific in-service incorporated within the training and it was covered in the preservice. (photographic evidence obtained)	A 081		

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A 081	Continued From page 50 Class III	A 081		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet	A 093		

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A 093	Continued From page 51 the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a	A 093		

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A 093	Continued From page 52 day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a 3-day supply of emergency water based on the current census. Findings: On at 12:30 PM, observation of the facilities emergency water revealed 120 gallons.	A 093		

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A 093	Continued From page 53 On at 12:35 PM, the Culinary Service Director stated that's all the water the facility has. The Culinary service Director further stated that she will put an order in. The current census of 72 residents x 1 gallon per resident x 3 days = 216 gallons - 120 on = 96 gallons short. On at approximately 6:15 PM, the Administrator was made aware of the water shortage. She stated the Culinary Service Director had just placed an order and there should be enough. Further stating, she would get the key to the closet where there was some additional water. On at 6:30 PM, the Administrator stated there was only an additional 24 gallons. The Administrator was made aware the current amount = 144. Therefore, bringing the total shortage to 72 gallons. Class III	A 093		
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.	A 160		

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A 160	Continued From page 54 (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, 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	A 160		

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A 160	Continued From page 55 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 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;	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969905	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDISON OF OVIEDO (THE)	1915 W COUNTY RD 419 CHULUOTA, FL 32766

(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 160	Continued From page 56 (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 ensure its discharge log identified the reason for discharge, and identification of the facility to which 1 of 1 sampled resident (#14) was discharged. Findings: Review of Resident #14's record revealed a facility note, dated , that showed the Resident was discharged from the facility. Review of the facility's move-out report revealed the move-out reason was relocation out of city/state. The report did not identify the reason and the facility to which the Resident was discharged. On at 1:18 PM, the Administrator said that within 2 or 3 days of the Resident's elopement on , the Resident's family moved her to a group care home. The Administrator said she did not ask the family for the name or address of the group care home. On at 1:42 PM, the Resident's family member said they decided to move her due to the facility telling them they had to place private sitters with her after the elopement and the cost to do so was too much. The family member	A 160		

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
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A 160	Continued From page 57 identified the name and address of the assisted living facility they transferred the Resident to. Class III	A 160		