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
	AL11910716	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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
ZZ875	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 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	ZZ875		

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ZZ875	Continued From page 1	ZZ875		

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 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,

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ZZ875	Continued From page 2 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), 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.	ZZ875		

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ZZ875	Continued From page 3 (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 record review and interview, the facility failed to ensure that 1 out of 4 sampled staff (Staff D) completed the mandatory 1-hour Department of Elder Affairs (DOEA) training for and Other Related and 3 hours of additional training within 30 days of employment. The findings include: A review of the Staff D's (CNA) file revealed a hire date of . Further review of the file revealed there was no documentation of a completed DOEA 1-hour training for 's and Other Related nor 3 hours of	ZZ875		

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ZZ875	Continued From page 4 additional training. During an interview with the Administrator on at 3:06 PM, she was notified that Staff D was missing the completed DOEA 1-hour training for 's and Other Related and the 3 hours of additional training. Class III	ZZ875		

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A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by	A 056		

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A 056	Continued From page 1 the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S.,	A 056		

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A 056	Continued From page 2 before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that unlicensed staff (Medication Technician) failed review the Medication Observation Record (MOR) and medication label at the time of medication pass for 1of 5 sampled resident (Resident #24). The findings included: An observation conducted on at 9:39 AM, during medication pass revealed that Staff C (Medication Technician) was assisting Resident #24 with the assistance of self administration of medication for the following medications: , . . 0.5 mg, one tablet every 8 hours, 6:00 AM, 2:00 PM and 10:00 PM , 81 mg, chew and swallow 1 tablet by daily with breakfast, 9:00 AM During an interview on at approximately 9:41 AM, Resident #24 was asked if she had eaten breakfast. She stated that she was not feeling well and had decided not to go to breakfast. During an interview on at 9:43 AM, Staff C was asked why he was not following the medication parameters (directions for use) for the following medications: 1) , 81 mg - Staff C did not advise the resident to chew and swallow the tablet and did not ask the resident if she had eaten breakfast	A 056		

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A 056	Continued From page 3 prior to administering the medication. 2) , 0.5 mg - Staff C was asked why the medication was administered three hours after the scheduled time indicated on the MOR and medication label. At that time, Staff C confirmed that he was not aware of the directions for use for both medications during the medication pass. During an interview on at approximately 3:00 PM, the Administrator and Operations Manager were informed of the concerns regarding the unlicensed staff (Medication Technician) not following established medication policies and procedures. Class III	A 056		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom	A 161		

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A 161	Continued From page 4 from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of compliance with staff training for 1 out of 3 sampled staff (Staff D).	A 161		

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A 161	Continued From page 5 The findings include: A review of Staff D's (Caregiver) file revealed a hire date of . Further review revealed the following concerns: 1) An unsigned, undated "Caregiver" job description 2) Undated Preservice Orientation training 3) Undated Resident Rights and , Neglect training 4) Undated training 5) Undated Elopement Response training 6) Undated Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting training 7) Undated Nutrition and Safe Food Handling training During an interview conducted with the Administrator on at 3:00PM, she was notified that Staff D's file was missing the appropriate documentation required due the lack of dates on the training. Furthermore, it was clarified that the lack of dates failed to meet the required timeframes necessary for the documentation and completion of said trainings. Class III	A 161		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race,	A 162		

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A 162	Continued From page 6 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌄ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed	A 162		

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consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , { }, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.
(m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.
(n) For hospice patients, the interdisciplinary care

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A 162	Continued From page 8 plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 observation, record review, and interview, the facility failed to maintain resident records on the premises that contained the required documentation for 1 out of 2 sampled residents (Resident #3). The findings include: During a tour of the facility conducted on from 9:21 AM to 9:26 AM, Resident #3 was observed lying in a hospice bed with full bedrails and the slightly elevated. Further	A 162		

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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 162	Continued From page 9 observation revealed, Staff B (MedTech) assisting the resident with self-administration of medication and assisting the resident with transferring. A review of Resident #3's file revealed an admission date of . Further review revealed a Resident Health Assessment (AHCA Form 1823) dated which documented the resident had diagnoses of , Aphasia, Left Side , . Additionally, he was documented as bedbound with "check for " precautions. Furthermore, the resident required total care with all activities of daily living and was receiving hospice services. The following items were missing from Resident #3's file: - Progress notes for the years 2024, 2025, and 2026 - Documentation of a power of attorney, legal guardian, or healthcare surrogate During an interview conducted with the Administrator on at 3:05 PM, she was notified that despite Resident #3 receiving hospice services and requiring total care, the facility had no documentation for his legal guardian/healthcare surrogate nor progress notes tracking his condition; indicating a lack of oversight of the resident's care needs. Class III	A 162		
A 000	Initial Comments An unannounced Relicensure, Complaint (#2026005355) and Generator Monitoring survey was conducted on at Northlake	A 000		

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	AL11910716	A. BUILDING: _____ B. WING _____	09/03/2026

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A 000	Continued From page 10 Living. The facility had deficiencies related to the Relicensure at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident	A 010		

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A 010	Continued From page 11 must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an	A 010		

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A 010	Continued From page 12 assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged	A 010		

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A 010	Continued From page 13 from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record	A 010		

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A 010	Continued From page 14 review, it was determined that the facility failed to ensure the residents' Health Assessments (AHCA Form 1823) were accurate and reflective of the residents' current care needs and diagnoses for 2 of 2 sampled residents (Residents #10 and #20). The findings included: During a facility tour on between approximately 8:30 AM and 3:00 PM, surveyors identified the following concerns. 1) An observation during breakfast on at Approximately 8:45 AM, Resident #20 was observed sitting on a Geri chair (, recliner, medical recliners designed for older adults and those with mobility issues) and fed by caregiver. During an attempted interview on at approximately 8:50 AM, Resident #20 was asked if she was in a comfortable position; however, she was unable to communicate and only smiled at the surveyor. During an interview on at approximately 9:00 AM, Staff G (Administrative Assistant Supervisor) stated the resident was total care, required a one person transfer, and was unable to communicate. Record review of Resident #20's file revealed Health Assessment signed by Advanced Practice Registered Nurse (APRN) and dated documented, diagnoses as unspecified , , physical limitations: Geri chair, , status as alert, receiving third party services (Hospice), special precautions: , , Activity of Daily Living (ADLs) as total care (staff completes the action for the resident) for the following: ambulation, , bathing, and grooming, and needs assistance (staff	A 010		

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A 010	Continued From page 15 provides physical assistance with the residents participation) eating, toileting and transferring. In review of the 1823 AHCA Form, the following concerns were identified: a) The resident's ADLs did not match observations. Resident #20 appeared to be total care (observed being fed by a caregiver), while the 1823 AHCA Form documented only special precautions for , and indicated that staff provided physical assistance with the resident's participation for eating. b) The resident was unable to communicate verbally with the surveyor, whereas the 1823 AHCA Form documented the resident's status as alert. During an interview on at approximately 2:00 PM, the Administrator was informed that Resident #20's 1823 AHCA Form did not reflect the resident's current care needs and diagnosis. She stated that she was hired a month ago, is still learning the residents' individual care needs and diagnoses and is working closely with the newly hired Operations Manager (Staff H) to make sure facility will have 1823 AHCA Forms reflective of care needs and diagnoses. No additional information was provided. 2) During an observation on at approximately 10:20 AM, Resident #10 was observed eating in the dining room while seated in a wheelchair. Additional observations revealed a list of residents identified as elopement risks posted outside the nurses' station located in the dining area.	A 010		

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A 010	Continued From page 16 During an attempted interview on at approximately 11:05 AM, Resident #10 was asked how his breakfast was; however, he was unable to communicate and only nodded and mumbled. During an interview on at approximately 11:15 AM, Staff G stated the resident is able to understand but has difficulty verbally expressing himself. Staff G was asked whether Resident #10 was total care, and she stated no. She was then asked to provide the resident's complete file. Record review of Resident #10's file revealed he was admitted on , Health Assessment signed by Advanced Practice Registered Nurse (APRN) and dated documented, diagnoses as , , , physical limitations as wheelchair transfer, ᵕ status as and aggressive at times, receiving third party services (home health services receiving , , , injections) and Activity of Daily Living (ADLs) as total for the following: ambulation, ᵕ, eating, self-care, toileting, transferring and bathing, and Elopement risk as, no. In review of the 1823 AHCA Form, the following concerns were identified: a) Resident's ADLs did not match observations; the resident was able to feed himself and ambulate with assistance. b) The resident was listed as an elopement risk (posted outside the nurses' station), but the 1823 AHCA Form documented not an elopement risk. c) The form documented physical limitations as wheelchair transfer and total care for ambulation, indicating the health assessment was unclear regarding the type of assistance the resident requires.	A 010		

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A 010	Continued From page 17 During an interview on at approximately 11:17 AM, Staff G stated Resident #10 is not total care. She added that she recently completed an audit but may have overlooked the 1823 AHCA Form. She was informed that observations and record reviews showed the resident's 1823 AHCA Form did not reflect the resident's current care needs and diagnosis.	A 010		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs.	A 031		

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A 031	Continued From page 18 (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection.	A 031		

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A 031	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, the facility failed to keep documented communication notes from Third Party Services/Providers, that were ordered by the physician for treatment and/or services for 8 of 8 sampled residents (Resident's # 10,11, 12, 13, 14, 15, 17 and 23). The findings included: During an interview on at approximately 9:30 AM, the Administrator was requested to provide a list of residents receiving third party services (Home Health) and the facility's Medication Observation Record (MOR) documenting administration of medication as ordered by the health care provider. . , , injections Record review of the facility's Third Party Services list, provided by Staff G (Administrative Assistant Supervisor), showed Resident's # 10,11, 12, 13, 14, 15, 17 and 23 each received injections ordered by the health care provider. Record review of the facility's MOR for Resident's # 10,11, 12, 13, 14, 15, 17 and 23 revealed there was no administration records for injections from the local Home Health agency, despite their daily presence on site at the facility. 1.) Record review of Resident # 10 showed an admission date of revealed medication: , 25 mg, ( ) every 2 weeks. Further review revealed that his file did not contain documentation of treatment notes from third party providers indicating medication	A 031		

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A 031	Continued From page 20 administration. In addition, there were no physician progress notes or communication/care coordination entries reflecting third party provider involvement. 2.) Record review of Resident #11 showed an admission date of revealed medication: Invega Trinza 819 mg, once every 3 months. Further review revealed that her file did not contain documentation of treatment notes from third party providers indicating medication administration. In addition, there were no physician progress notes or communication/care coordination entries reflecting third party provider involvement. 3.) Record review of Resident #12 showed an admission date of revealed medication: Invega Sustenna 156 mg, every 30 days starting . Further review revealed that her file did not contain documentation of treatment notes from third party providers indicating medication administration. In addition, there were no physician progress notes or communication/care coordination entries reflecting third party provider involvement. 4.) Record review of Resident #17 showed an admission date of revealed medication: , Consta 25 mg, , administer every 2 weeks. Further review revealed file did not contain documentation of treatment notes from third party providers indicating medication administration. In addition, there were no physician progress notes or communication/care coordination entries	A 031		

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A 031	Continued From page 21 reflecting third party provider involvement. 5.) Record review of Resident #14 showed an admission date of revealed medication: , 100 mg, , every four weeks. Further review revealed that her file did not contain documentation of treatment notes from third party providers indicating medication administration. In addition, there were no physician progress notes or communication/care coordination entries reflecting third party provider involvement. 6.) Record review of Resident #15 showed an admission date of revealed medication: , 100 mg, , inject 3 ml once monthly. Further review revealed that her file did not contain documentation of treatment notes from third party providers indicating medication administration. In addition, there were no physician progress notes or communication/care coordination entries reflecting third party provider involvement. 7.) Record review of Resident #13 showed an admission date of revealed medication: Day One, Start Invega Suspenna, 234 mg, , Day 8 give Invega Sustenna 156 mg, Home Health to follow for treatment. Further review revealed that her file did not contain documentation of treatment notes from third party providers indicating medication administration. In addition, there were no physician progress notes or communication/care coordination entries reflecting third party provider involvement. 8.) Record review for Resident #23 showed an	A 031		

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A 031	Continued From page 22 admission date of . Revealed medication: , 50 mg, to inject 1 ml twice monthly, with the prescription order dated . The file did not contain documentation indicating when the first injection was administered, and therefore the next scheduled injection date could not be determined. No additional treatment notes from the third party provider were found to indicate medication administration. The resident records contained no information that would allow the facility to verify what services were rendered, when they occurred, or whether they were consistent with the residents' assessed needs and service plans. During an interview on at approximately 2:45 PM, surveyors informed the Administrator and Operations Manager of concern that the facility failed to provide required written communication from third party providers regarding ordered treatments and services. Class III	A 031		
A 033	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will	A 033		

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A 033	Continued From page 23 monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined that, the facility failed to ensure that residents residing in the secure unit had written care plans the use of a chair (Geri Chair). This failure has the potential to negatively impact residents' comfort, physical well being, and participation in facility activities according to their needs, for 1 of 1 sampled resident (Resident #20). Cross reference A0010 for additional information regarding Resident #20. The findings included: Review of the facility's policy and procedures revealed a Physical Policy that was undated and documented as follows: Policy The facility must ensure that the device is applied appropriately and safely as prescribed by the physician.	A 033		

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	AL11910716	A. BUILDING: _____ B. WING _____	09/03/2026

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A 033	Continued From page 24 Procedure Residents for whom a physician has prescribed a physical restrain must have a written care plan for the use of the physical restrain. The care plan must be developed withing 14 days of the device being prescribed and prior to its use on the resident. (a) The care plan must specify: 1. The device prescribed for use 2. The maximum amount of time the resident is to have the restrain applied each day. 3. The manner and frequency in which staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed restrain. (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical restrain annually, and documentation of this review must be maintained in the resident's record. During the facility tour on from approximately 8:15 AM to 3:00 PM, Resident #20 was observed seated in a Geri chair in the corner of the activity / dining area (east side of the building), unsupervised, sleeping, and leaning on her right side. The resident remained in the Geri chair from morning until bedtime. Direct care staff interviews confirmed she was not given an opportunity to lie down for a nap. Additional observations showed that the resident remained in the Geri chair without timely	A 033		

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A 033	Continued From page 25 repositioning, ate lunch and slept in the chair, and was observed sliding down; she was only moved during toileting and was not offered opportunities to leave the device. The facility did not follow practices demonstrating compliance with regulatory requirements to ensure Resident #20 received proper positioning, adequate mobility assistance, and opportunities to engage in activities consistent with her physical capabilities. During an interview on at approximately 1:00 PM, Staff G (Administrative Assistant Supervisor) was informed of the identified concerns. At that time, she confirmed that Resident #20 was total care and stated that the Geri chair was the best option for the resident's comfort and ambulation based on her Activities of Daily Living (ADLs). Staff G was asked to provide the resident's complete file, including the care plan for the use of the Geri chair. Record review of Resident #20's file revealed Health Assessment signed by Advanced Practice Registered Nurse (APRN) and dated documented, diagnoses as unspecified , , , physical limitations: Geri chair, receiving third party services (Hospice), ADLs as total care (staff completes the action for the resident) for the following: ambulation, , bathing, and grooming. Further record review revealed no written care plan developed within 14 days of the device being prescribed and prior to its use. The review also showed no documentation indicating the maximum amount of time Resident #20 should spend in the Geri chair each day. No written	A 033		

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A 033	Continued From page 26 documentation was provided to support how staff monitored, observed, and reported use of the Geri chair to the Administrator or health care provider. Additionally, the facility did not provide evidence of the health care provider's annual review for continued appropriateness of the device, nor was such documentation maintained in the resident's record. During an interview on at approximately 3:00 PM, the Administrator and Operations Manager were reminded that the facility is responsible for ensuring that the use of devices complies with regulatory requirements. Class III	A 033		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include:	A 036		

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A 036	Continued From page 27 hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on record review, observations, and interviews, it was determined that the facility failed to ensure that unlicensed staff (Medication Technician) implemented control procedures while assisting a resident with self administration of medication, including proper medication handling during the medication pass, for 1 of 5 sampled residents (Resident #16). The findings included: An observation conducted on at approximately 9:15 AM during medication pass revealed that Staff C (Medication Technician) was assisting Resident #16 with the assistance of self-administration of medication for the following medications: , 325 mg, 9:00 AM , 0.5 mg, 9:00 AM , 75 mg, 9:00 AM 0.5 mg, 9:00 AM , 2.5 mg, 9:00 AM 325 mg, 9:00 AM Megestrol 20 mg, 9:00 AM 5 mg, 9:00 AM , 20 mg, 9:00 AM Multivit - -one daily, 9:00 AM 100 mg, 9:00 AM 0.4 mg, 9:00 AM	A 036		

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A 036	Continued From page 28 B1 100 mg, 9:00 AM Zenpep 5,000 unit, 9:00 AM Further observations revealed that Staff C used his bare ⌄ to remove the medication from the pill pack and placed the pills into the medication cup. During an interview on at 9:18 AM, Staff C was asked why he used his bare ⌄ to remove the medication from its pill pack. He was also asked what's the facility protocol and/or policy and procedures regarding control. At that time, he acknowledged the findings. During an interview on at approximately 3:00 PM, the Administrator and Operations Manager were informed of the concerns regarding the unlicensed staff (Medication Technician) not implementing control procedures while assisting a resident with self administration of medication. Class III	A 036		