

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963788</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/31/2021</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**PANORAMA LIVING**

**1030 BALMY BEACH DRIVE  
APOPKA, FL 32703**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 000}                  | Initial Comments<br><br>A third revisit to complaint investigations (2020016935 and 2020012656) was conducted at Panorama Living Assisted Living Facility on ..... A deficiency remained uncorrected at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {A 000}             |                                                                                                                          |                          |
| {A 152}<br>SS=D          | 59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and,<br>3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.<br>(b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:<br>1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable ..... to ensure easy access by the resident,<br>2. A closet or wardrobe space for hanging clothes,<br>3. A dresser, ..... or other furniture designed for storage of clothing or personal effects,<br>4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.<br>(d) Residents who use portable bedside | {A 152}             |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                                                                                                          |                          |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963788</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/31/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PANORAMA LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1030 BALMY BEACH DRIVE</b><br><b>APOPKA, FL 32703</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 152}                                                    | <p>Continued From page 1</p> <p>commodes must be provided with privacy during use.</p> <p>(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . .</p> <p>This Statute or Rule is not met as evidenced by:<br/>DEFICIENCY REMAINED UNCORRECTED</p> <p>Based on observations and interview, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment that was free from black and brown substances on the ceiling.</p> <p>Findings:</p> <p>Observations on . . . . . at 9:30 AM, revealed when passing through the kitchen there was a hallway next to the bathrooms, the ceiling of that area had large black brown stains.</p> <p>On . . . . . at 9:40 AM, the caregiver confirmed the findings and stated someone was supposed to start working on it today.</p> <p>Class III</p> | {A 152}                                                                                           |                                                                                                                          |                          |                                                                    |