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
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
CZ821	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 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.	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
CZ821	Continued From page 1 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?No=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	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
CZ821	Continued From page 2 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. 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. 6. 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. 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	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
CZ821	Continued From page 3 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 the facility's documentation and interview, the facility failed to electronically submit an Adverse Incident report timely to the Agency for Health Care Administration (AHCA) for 1 of 6 sampled residents (#15) that resulted a with a . Findings: In , resident #15 and his , and left , . He also had , replacement surgery. He returned to the facility and 10 more times between and . The family member finally discharged him from the Assisted Living Facility on to a higher level of care. Resident #15's record revealed an admission date of . The last 1823 Health Assessment dated listed a medical history of with a , , , , and to left side , and , . He needed total care for bathing, , and grooming with Activities of Daily Living (ADLs), assistance with ambulation, transferring and toileting, and supervision with eating. He needed	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
CZ821	Continued From page 4 medication administration. He finally was admitted to Hospice care on . There was no documented evidence that the facility reported this incident to the agency as required during that time. On at 3:50 PM, an interview with the Administrator confirmed the findings. Unclassified	CZ821		
A 000	Initial Comments A Re-licensure survey with Extended Congregate Care (ECC), a Complaint Investigation #2022008567, and a Generator Monitoring were conducted on . Zon Beachside had deficiencies 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 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	A 010		

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
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 010	Continued From page 5	A 010		

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 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 [illegible].
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

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
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 010	Continued From page 6 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-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	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 010	Continued From page 7 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 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	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 010	Continued From page 8 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 record reviews and interview, the facility failed to ensure 1 of 6 sampled residents had a plan of care which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident (#2). Findings: Resident #2's record revealed the resident was admitted to the facility under hospice services on . The record did not contain a plan of care which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident. On ..... at 3:05 PM, the finding was discussed with both the director of nursing (DON) and the assistant director of nursing (ADON), and an opportunity was given to provide additional documentation. On at 4:15 PM, the ADON provided additional hospice documents however, none of	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 010	Continued From page 9 them were the required plan of care. 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 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.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 10 (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 record reviews and interviews, the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries for 1 of 6 sampled residents (#15), and failed to follow health care provider orders for 1 of 6 sampled residents who received assistance with self-administration of medications (#1). Findings: 1. Resident #15's record revealed an admission date of . The last 1823 Health Assessment dated listed medical	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 11 history of [redacted] with a [redacted] and [redacted] to left side [redacted] and [redacted]. He needed total care for bathing, [redacted], and grooming with Activities of Daily Living (ADLs), assistance with ambulation, transferring and toileting, and supervision with eating. He needed medication administration. Photographic evidence was obtained. There was no documented evidence of resident #15 falling sometime in [redacted] resulting a [redacted], and getting a [redacted] replacement before returning to the Assisted Living Facility. On [redacted], the hospital records of the [redacted], and [redacted] replacement surgery after a [redacted] in [redacted] were reviewed. Resident #15 [redacted] ten other times within from [redacted] to [redacted], documented with and without injury. The family member discharged the resident from the facility on [redacted] to a higher level of care. Facility notes documented each occurrence below: [redacted] at 3:52 PM 1st [redacted] - resident #15 loss his balance inside his apartment kitchen; a neighbor of resident #15 called for help. He was found lying on the floor on his left side, complaining of [redacted] and unable to move. Vital signs were completed but the facility never notified the family member and healthcare provider of the [redacted] and never sent the resident out to hospital. [redacted] at 9:50 PM 2nd [redacted] - resident #15 was found in his room at 7:30 PM lying on the floor on his right side. He stated that he was trying to get to the bathroom. His daughter had	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 12 called when he and heard it on the phone. The daughter notified the facility's nurse of this incident. He developed a small on his right inner bicep and first aid was applied with of steri strips, Telfa and Hypafix. He was lifted with two persons assistance into his bed and given his call pendent and a . at 1:35 AM 3rd - resident #15 was found sitting on the floor in front of his recliner chair. No injury was noted and the resident did not complain of . He was assisted by 2 persons and helped into the bed. The family member was notified but not the healthcare provider. - resident #15 was admitted to Hospice care. at 7:19 PM 4th - resident #15 got up from his recliner chair, attempted to ambulate a few and on his . No injury was noted. The family member and the healthcare provider were never notified of this . at 2:14 AM 5th - resident #15 was observed on the floor in a supine position. The resident stated he hit his . Staff notified the resident's daughter and requested he go to the emergency room for further evaluation. Staff left the healthcare provider a voicemail. at 1:39 PM 6th - an unlicensed staff went to assist resident #15 to the bathroom and found resident #15 on the floor. The resident said that he was putting on his pants. A was seen on his right . His daughter was notified but the healthcare provider was never notified. at 11:44 AM 7th - resident #15's	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 13 wife called for help to a Medication Technician in the hallway. He was found on the floor and was assisted into his recliner chair. There was some dried on his right , which was scraped. No was required; the daughter was notified but the healthcare provider was not notified. at 9:49 PM 8th - resident #15 went to sit on the edge of his bed and missed, sliding down to the floor. No injuries were noted. The resident did not complain of . The Director of Nursing and another nurse assisted resident #15 into standing position and helped him to his recliner chair. Family and the Advanced Practitioner Registered Nurse (APRN) were notified. at 1:10 AM 9th - resident #15 was found seated on the floor next to his bed and his leaning against the nightstand. This was the second time he was found on the floor within the past 3 hours. The first time he slid off his bed. He could not explain what he was doing when he . Vital signs were within normal range, he had no , , and there was no and . He was assisted into bed. The daughter and Hospice services were notified. at 3:31 PM 10th - resident #15 trying to get into his wheelchair from bed. The brakes on wheelchair were not on. Vital signs were normal. The family was notified but Hospice was not notified. There was no documented evidence of what the facility put in place for prevention and there was no documentation of the left , and , documented on last 1823 Health Assessment dated .	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 14 The facility did not have a Prevention policy and procedures for residents who had multiple and were a high risk for . The Administrator provided a policy on resident informed choice documenting two sentences on accidental trips and as stated: "Unfortunately become an increasing risk with age. While interventions can be implemented to possibly reduce , they cannot be eliminated." The Administrator confirmed this was all they had for risk residents. Photographic evidence was obtained. On at 3:30 PM, an interview with the Administrator and Assistant Director of Nursing (ADON) confirmed the findings. 2. Resident #1's record revealed a facility admission date of . An 1823 assessment form, dated , indicated the resident required assistance with self-administration of medications. The resident's diagnoses were 's , acute in left ankle and with , Bodies, , , Sleep , , and of native of left with of heel and midfoot. Review of the resident's MOR revealed the following entries: , 25 milligrams (mg) 1 tablet by every evening (5 PM), hold for ( ) <110 or < (B/P) check twice a day (9 AM & 8 PM) and give for >160. Review of the (B/P) and rate readings that were documented during	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 15 [redacted] revealed the resident's B/P and rate were not checked each time , was given and not always checked twice a day, as ordered. On at 3:05 PM, the findings were discussed with both the Director of Nursing (DON) and the ADON, who both confirmed the findings, and an opportunity was given to provide additional documentation. On at 5:36 PM, the ADON said the resident's B/P was not checked prior to each time , was given. Class II	A 025		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 034	Continued From page 16 using the assistive device. This Statute or Rule is not met as evidenced by: Based on review of the facility's assistive devices policy and interview, the facility failed to ensure the policy addressed the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. Findings: Review of the facility's undated assistive device policy did not address the requirements and methods for assessing the physical condition of assistive devices that may injure the resident, and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. On . . . . . at 4 P.M., the administrator confirmed the findings and said the policy he provided was the only one the facility had that addressed assistive devices. Class III	A 034		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 054	Continued From page 17 and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to properly update a Medication Observation Record (MOR) for 2 of 6 sampled residents (#1 & #2). Findings: 1. Resident #1's record revealed a facility admission date of [illegible]. An 1823 Assessment form (1823), dated [illegible], indicated the resident required assistance with self-administration of medications. The resident's diagnoses were [illegible]'s [illegible], acute [illegible] in left ankle and [illegible],	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 054	Continued From page 18 with , Bodies, , Sleep , , , , and of native of left with of heel and midfoot. Resident #1's MOR revealed there were empty spaces where medications were not signed as given. Neither the MOR nor the resident's record contained documentation to explain the omissions. On at 3:05 PM, the findings were discussed with both the Director of Nursing (DON) and the Assistant DON (ADON), but neither were able to provide additional documentation. 2. Resident #2's record revealed a facility admission date of . An 1823, dated , indicated the resident required assistance with self-administration of medications. The resident's diagnoses were and . Resident #2's MOR revealed there were empty spaces where medications were not signed as given. Neither the MOR nor the resident's record contained documentation to explain the omissions. On at 4:15 P.M., the findings were discussed with the ADON, who confirmed the findings. Class III	A 054		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 084	Continued From page 19 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 084	Continued From page 20 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate,	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 084	Continued From page 21 temperature, and . . , . . . , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on personnel record review, review of . . . . . Medication Observation Record (MORs) and interview, the facility failed to obtain initial 6 hours training in assisting with self-administration of medications and safe	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 084	Continued From page 22 medication practices in an assisted living facility completed for 1 of 4 sampled staff (B). Findings: Medication Technician (Med Tech) B's personnel record revealed a hire date of . . . . . There was no documented evidence of an initial 6 hour medication training completed in the file. On . . . . . , the . . . . . MORs for resident #2 indicated that Med Tech B assisted with self-administration of medications and signed off for the following: . . . . . , / . . . . . , 25-100 milligrams (mg) at 8 AM and 12 PM on . . . . 125 mg at 8 AM and on . . . . . at 8 AM Acidophilus at 8 AM on . . . . . and . . . . . at 8 AM . . . . , 1% . . . . . at 9 AM on . . . . . . Photographic evidence was obtained. On at 2:15 PM, an interview with Med Tech B confirmed that she assisted residents with self-administration of medications. On at 4 PM, an interview with the Administrator confirmed the findings. Class III	A 084		
A 093 SS=F	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, 2010,	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 093	Continued From page 23 which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. 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 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	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 093	Continued From page 24 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 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.	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 093	Continued From page 25 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 record review and interview, the facility failed to have water as part of their 3-day emergency food supply. Findings: On . . . . . at 1 PM, the Dietary Manager said they do not keep bottled water on site for emergency use. He said the Maintenance Director oversaw the water and he believes they use water . . . . . for emergency use. He said he would get with the maintenance director and find out. On . . . . . , a review of the facility's Comprehensive Emergency Management Plan (CEMP) did not reveal any documentation for the use of water for storage of water during	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 093	Continued From page 26 an emergency. On [redacted] at 2:30 PM, the maintenance man said the facility would use water during an emergency. They have two 150-gallon and one 300-gallon. They are stored offsite. He confirmed the [redacted] were not included in the facility's CEMP. Class III	A 093		
A 180 SS=D	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan in accordance with the "Emergency Management Criteria for Assisted Living Facilities," dated [redacted], which is incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-04010. This document is available from the local emergency management agency. The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications;	A 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 180	Continued From page 27 (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with . . . . . 's or related , and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the local emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the local emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to include the use of . . . . . , for water storage, in their Comprehensive Emergency Management Plan (CEMP). Findings: On at 1 PM, the Dietary Manager said they do not keep bottled water on site for emergency use. He said the Maintenance Director was in charge of the water and he believes they use water for emergency use. He said he would get with the maintenance director and find out. On , a review of the facility's CEMP did	A 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 180	Continued From page 28 not reveal any documentation for the use of water for storage of water during an emergency. On . . . . . at 2:30 PM, the maintenance man said the facility would use water during a emergency. They have two 150-gallon . . . . . and one 300-gallon. They are stored offsite. He confirmed the . . . . . were not included in the facility's CEMP. Class III	A 180		
AE208 SS=D	59A-36.021(8) FAC 429.07(3)(b)3, FS ECC - Records 59A-36.021(8) RECORDS. (8) RECORDS. In addition to the records required in rule 59A-36.015, F.A.C., a facility providing extended congregate care services must maintain the following: (a) The service plans for each resident receiving extended congregate care services; (b) The nursing progress notes for each resident receiving nursing services from the facility's staff; (c) Nursing assessments; and, (d) The facility's extended congregate care policies and procedures. 429.07 (3)(b), FS 3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the	AE208		

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
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
AE208	Continued From page 29 facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has: a. Held an extended congregate care license for at least 24 months; b. No class I or class II violations and no uncorrected class III violations; and c. No ombudsman council complaints that resulted in a citation for licensure. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain written nursing progress notes on 1 of 6 sampled residents who received Extended Congregate Care (ECC) services for a [redacted] (#1). Findings: 1. Resident #1's record revealed a facility admission date of [redacted]. An 1823 Assessment form (1823), dated [redacted], indicated the resident required assistance with self-administration of medications. The resident's diagnoses were [redacted]'s [redacted], acute [redacted] in left ankle and [redacted], with [redacted], Bodies, [redacted], and Sleep [redacted].	AE208		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969028	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
AE208	Continued From page 30 of native of left with of heel and midfoot. The resident's admission documents contained an order summary, dated , to cleanse the left heel with normal or cleanser, dry, apply powder to the bed with Silver , and cover with foam daily. On at 10:40 AM, the Assistant Director of Nursing (ADON) identified resident #1 as receiving ECC services for care to a on the resident's left heel. An ECC service plan, dated , indicated the service provided was care. Review of facility's ECC nursing progress notes revealed the notes for the resident's left heel care did not describe the treatment provided to the , the general status of the resident's health, and the credential initials of the person who rendered the treatment. On at 3:05 PM, the findings were discussed with both the Director of Nursing (DON) and the ADON, who confirmed the findings and who were unable to provide additional documentation. Class III	AE208		