

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 000	Initial Comments A complaint investigation (complaint number: 2024005293) and a generator monitoring were conducted at The Club at Haines City on Deficiencies were identified at the time of 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 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,	A 010			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 1 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 _____. 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.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 2 (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 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,	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 3 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 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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an updated health assessment when a resident had been admitted to hospice. Additionally, the facility failed to obtain an interdisciplinary care plan that described the care and services that hospice provided and those that the facility provided and was agreed upon by hospice, the facility, and the resident (or responsible party) for one (Resident #2) of one sampled resident that was bedridden. Findings Included: A record review for Resident #2, conducted on , revealed that Resident #2's date of admission was not noted in the resident's record. The date that Resident #2 was admitted to hospice services was not noted in the resident's record. Resident #2's most recent health assessment dated did not note the resident's required nursing or treatment services of hospice on page one. The health assessment noted that Resident #2 was bedridden. There was no interdisciplinary care plan that specified the care and services that hospice provided and those that the facility provided and were agreed upon by hospice, the facility, and the resident (or resident's responsible party. During an interview with the Administrator and Wellness Director, conducted on at 03:28pm, the Administrator and Wellness Director agreed that Resident #2's health assessment form did not note the resident's required nursing services of hospice on page one. The Administrator and Wellness Director agreed that there was no interdisciplinary care plan in place	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE CLUB AT HAINES CITY

**301 PENINSULAR DRIVE
HAINES CITY, FL 33844**

(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 that described the care and services that were provided by hospice and the care and services that were provided by the facility. Class III	A 010		
A 052 SS=D	429.256() ; 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an _____ syringe that is prefilled with the proper dosage by a pharmacist and an _____ that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her _____. (d) Applying _____ medications. (e) Returning the medication container to proper	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 6 storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844			
(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 052	Continued From page 7 discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 8 facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure proper assistance with self-administration of medications by not popping medications from pill packs in front of residents and not reading the names and doses of the medications from the medication labels for one (Resident #3) of one sampled	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 9 resident that required assistance with self-administration of medication. Findings Included: During a medication pass observation with Staff A (an unlicensed Medication Technician) for Resident #3, conducted on _____ from 10:52am through 10:57am, Staff A popped Resident #3's prescribed medications Diltazem 90mg, _____ 100mg, _____ 10mg, _____ 500mg, Rivastigine 1.5mg, 100mg, and _____ D3 5000 units from the pill packs into a plastic pill cup at the medication cart. There was no resident present. Staff A placed the pill packs _____ into the medication cart. Staff A took the plastic pill cup of Resident #3's medications into the resident's room. Staff A gave Resident #3 the plastic pill cup of the medications. Staff A did not read the names and doses of the medications from the medication labels to Resident #3. A record review for Resident #3, conducted on _____, revealed that Resident #3 was admitted to the facility on _____. According to Resident #3's health assessment form dated _____, the resident required assistance with self-administration of medications. There was no waiver in Resident #3's record for unlicensed Medication Technicians not to read the medication names and doses to the resident. During an interview with the Administrator, conducted on _____ at 03:20pm, the Administrator agreed that medications were to be popped from pill packs in front of residents. The Administrator agreed that unlicensed Medication Technicians were to read the names and doses of the medications to the resident from the	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 10 medication labels. During an interview with the Wellness Director, conducted on _____ at 03:00pm, the Wellness Director agreed that medications were to be popped from pill packs in front of residents. The Administrator agreed that unlicensed Medication Technicians were to read the names and doses of the medications to the resident from the medication labels. Class III	A 052		
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 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 _____ 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,	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 11 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 _____, 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 review and interview, the facility failed to ensure that medication observation records (MORs) were updated immediately each time medications were given to three (Residents #8, #9, and #10). Additionally, the facility failed to ensure that MORs did not contain errors for one Resident (#8). Furthermore, the facility failed to ensure that directions of use were noted on MORs for one (Resident #10) of seven sampled residents that required assistance with self-administration of medications. Findings Included: A record review for Resident #8, conducted on _____, revealed that Resident #8 was admitted to the facility on _____. According to Resident #8's health assessment form dated _____, the resident required assistance with self-administration of medications. Resident #8's MORs had prescribed medications that were not documented as given to the resident which included _____ 12.5mg dose and _____ 25mg dose. The medication _____ was misspelled as Sertaline for both doses. _____ 25mg take a half tablet every day for seven days was not documented as given from _____ through _____ and _____ through _____ at 08:00am. _____ 25mg take one full tablets every day was not documented as	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 12 given on and at 08:00am. A record review for Resident #9, conducted on, revealed that Resident #9 was admitted to the facility on, According to Resident #9's health assessment form dated, the resident required assistance with self-administration of medications. Resident #9's MORs had prescribed medications that were not documented as given to the resident which included 40mg on at 06:00am and at 08:00pm, 1 Gram on at 08:00pm, and 5mg on at 08:00pm. A record review for Resident #10, conducted on, revealed that Resident #10 was admitted to the facility on, According to Resident #10's health assessment form dated, the resident required assistance with self-administration of medications. Resident #10's MORs had a prescribed medication that was not documented as given to the resident which included 20mg on at 06:00am. Resident #10's MORs noted 1% 2 Gram Patch apply to affected area four times every day. The affected area to treat was not noted. Resident #10's MORs noted 0.77% Cream apply to affected twice every day. The specific or for the specific was not noted on the MORs. During an interview with the Wellness Director, conducted on at 03:00pm, the Wellness Director agreed that Residents #8, #9, and #10's MORs had medications that were not documented as given to the residents. The Wellness Director agreed that was misspelled on Resident #8's MORs. The Wellness Director agreed that the affected areas	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE CLUB AT HAINES CITY

**301 PENINSULAR DRIVE
HAINES CITY, FL 33844**

(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 13 were not noted on Resident #10's MORs for the medications Patch and Cream. Class III	A 054		
A 056 SS=D	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	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 14 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, faxed, or electronic copy of a medication order issued and signed by 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	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 15 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., 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, the facility failed to provide prescribed medications as ordered from residents' health care providers and failed to notify the residents' health care providers that residents did not receive their medications as prescribed for seven (Residents #2, #3, #7, #8, #9, #10, and #11) of seven sampled resident that required assistance with self-administration of medications. Findings Included: During a medication pass observation with Staff A for Resident #3, conducted on _____ from 10:52am through 10:57am, Staff A provided Resident #3 with the prescribed 08:00am medications Diltazem 90mg, _____ 100mg, _____ 10mg, _____ 500mg, Rivastigine 1.5mg, _____ 100mg, and _____ D3 5000. During an interview with Staff A, conducted on _____ at 10:58am, Staff A stated that Residents #2, #7, #8, #9, #10 and #11 had not received their scheduled 08:00am yet. Staff A	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 16 stated that the facility usually had three unlicensed Medication Technicians on duty but had two during the survey. During interviews with Residents #7, #8, #9, #10, and #11, conducted on _____ from 11:05am through 11:25am, Residents #7, #8, #9, #10, and #11 stated that they had not received their prescribed 08:00am medications during survey. A record review for Resident #2, conducted on _____, revealed that Resident #2's admission date was not noted in the resident's record. According to Resident #2's health assessment form dated _____, revealed that the resident required assistance with self-administration of medications. Resident #2's MORs had medications that were documented as not given to the resident which included _____ 40mg, _____ 100mg, _____ 60mg, _____ 5mg, _____ 5mg, _____ 40mg, _____ 500mg, Ensure Dietary Supplement, and _____ due to the resident's refusals. There was no evidence that the facility notified Resident #2's primary care provider or responsible party that the resident did not receive the medications as prescribed. Resident #2's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:31am on _____. A record review for Resident #3, conducted on _____, revealed that Resident #3 was admitted on _____. According to Resident #3's health assessment form dated _____, revealed that the resident required assistance with self-administration of medications. Resident #3's MORs had medications that were documented as not given to the resident which	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE CLUB AT HAINES CITY

**301 PENINSULAR DRIVE
HAINES CITY, FL 33844**

(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 056	Continued From page 17 included stockings due to the resident's refusals or other. There was no evidence that the facility notified Resident #3's primary care provider or responsible party that the resident did not receive the stockings as prescribed. Resident #3's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:02am on A record review for Resident #7, conducted on, revealed that Resident #7 was admitted on According to Resident #7's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #7's MORs had medications that were documented as not given to the resident which included 40mg, ... 12.5, ... 0.4mg, ... 0.5mg, and 5/235mg due to the resident's refusals. There was no evidence that the facility notified Resident #7's primary care provider or responsible party that the resident did not receive the medications as prescribed. Resident #7's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:24am on A record review for Resident #8, conducted on, revealed that Resident #8 was admitted on According to Resident #8's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #8's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:05am on A record review for Resident #9, conducted on	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 18 , revealed that Resident #9 was admitted on, According to Resident #9's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #9's MORs had medications that were documented as not given to the resident which included Tears due to the resident's refusals or other. There was no evidence that the facility notified Resident #9's primary care provider or responsible party that the resident did not receive the medication as prescribed. Resident #9's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:09am on A record review for Resident #10, conducted on, revealed that Resident #10 was admitted on, According to Resident #10's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #10's MORs had medications that were documented as not given to the resident which included 120mg, ... 25mg, ... 10mg, Diclogenic Patch, ... Cream, ... Cream, ... 5mg, ... 100mg, and 50mg due to the resident's refusals. There was no evidence that the facility notified Resident #10's primary care provider or responsible party that the resident did not receive the medications as prescribed. Resident #10's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:31am on A record review for Resident #11, conducted on, revealed that Resident #11's MORs had medications that were documented as not given to the resident which included	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 19 200mg, _____ 1mg, _____ 1000mg, _____ 2mg/5ml Syrup, and _____ 1.5mg due to the resident's refusals. There was no evidence that the facility notified Resident #11's primary care provider or responsible party that the resident did not receive the medication as prescribed. Resident #11's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:36am on _____. During an interview with the Wellness Director, conducted on _____ from 03:00pm through 03:18pm, the Wellness Director reviewed the times stamps for Residents #2, #3, #7, #8, #9, #10, and #11 and the Wellness Director agreed that the residents received their 08:00am scheduled prescribed medications was given outside of the timeframe to give residents their medications no more that one hours before or one hour after a medication was scheduled. The Wellness Director was not able to provide evidence that Residents #2, #3, #7, #8, #9, #10, and #11 primary care providers or responsible parties were notified that they did not received medications as prescribed. During an interview with the Administrator conducted on _____ at 02:30pm, the Administrator stated that medications were to be given no more than one hour before the scheduled time and no more than one hour after the medications was scheduled. Class III	A 056			
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 152	Continued From page 20 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (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: 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 height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (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 This Statute or Rule is not met as evidenced by: Based on observation, record review, and	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 152	Continued From page 21 interview, the facility failed to ensure that carpets were clean and decent throughout the facility. Findings Included: During observations of the carpeting through three of four hallways, conducted on at 10:45am, the carpeting appeared worn with tears and frayed areas. The Carpeting had many brown stains on each hallway which included but was not limited to in front of rooms A33, 37, 43, and the janitor's room.(photographic evidence obtained). During an attempt to review floor replacement services in process, conducted on , none were provided. During an interview with the Administrator, conducted on at 03:15pm, the Administrator stated that cleaning the carpets was pointless and would not remove the stains anymore. The Administrator agreed that the carpets needed to be replaced and were unsightly. Class III	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 000	Initial Comments A complaint investigation (complaint number: 2024005293) and a generator monitoring were conducted at The Club at Haines City on Deficiencies were identified at the time of 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 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,	A 010			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 1 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 _____. 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.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 2 (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 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,	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844			
(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 3 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 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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an updated health assessment when a resident had been admitted to hospice. Additionally, the facility failed to obtain an interdisciplinary care plan that described the care and services that hospice provided and those that the facility provided and was agreed upon by hospice, the facility, and the resident (or responsible party) for one (Resident #2) of one sampled resident that was bedridden. Findings Included: A record review for Resident #2, conducted on , revealed that Resident #2's date of admission was not noted in the resident's record. The date that Resident #2 was admitted to hospice services was not noted in the resident's record. Resident #2's most recent health assessment dated did not note the resident's required nursing or treatment services of hospice on page one. The health assessment noted that Resident #2 was bedridden. There was no interdisciplinary care plan that specified the care and services that hospice provided and those that the facility provided and were agreed upon by hospice, the facility, and the resident (or resident's responsible party. During an interview with the Administrator and Wellness Director, conducted on at 03:28pm, the Administrator and Wellness Director agreed that Resident #2's health assessment form did not note the resident's required nursing services of hospice on page one. The Administrator and Wellness Director agreed that there was no interdisciplinary care plan in place	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 that described the care and services that were provided by hospice and the care and services that were provided by the facility. Class III	A 010			
A 052 SS=D	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying medications. (e) Returning the medication container to proper	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 6 storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 7 discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 8 facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure proper assistance with self-administration of medications by not popping medications from pill packs in front of residents and not reading the names and doses of the medications from the medication labels for one (Resident #3) of one sampled	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 9 resident that required assistance with self-administration of medication. Findings Included: During a medication pass observation with Staff A (an unlicensed Medication Technician) for Resident #3, conducted on _____ from 10:52am through 10:57am, Staff A popped Resident #3's prescribed medications Diltazem 90mg, _____ 100mg, _____ 10mg, _____ 500mg, Rivastigine 1.5mg, 100mg, and _____ D3 5000 units from the pill packs into a plastic pill cup at the medication cart. There was no resident present. Staff A placed the pill packs _____ into the medication cart. Staff A took the plastic pill cup of Resident #3's medications into the resident's room. Staff A gave Resident #3 the plastic pill cup of the medications. Staff A did not read the names and doses of the medications from the medication labels to Resident #3. A record review for Resident #3, conducted on _____, revealed that Resident #3 was admitted to the facility on _____. According to Resident #3's health assessment form dated _____, the resident required assistance with self-administration of medications. There was no waiver in Resident #3's record for unlicensed Medication Technicians not to read the medication names and doses to the resident. During an interview with the Administrator, conducted on _____ at 03:20pm, the Administrator agreed that medications were to be popped from pill packs in front of residents. The Administrator agreed that unlicensed Medication Technicians were to read the names and doses of the medications to the resident from the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 052	Continued From page 10 medication labels. During an interview with the Wellness Director, conducted on _____ at 03:00pm, the Wellness Director agreed that medications were to be popped from pill packs in front of residents. The Administrator agreed that unlicensed Medication Technicians were to read the names and doses of the medications to the resident from the medication labels. Class III	A 052			
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 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 _____ 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,	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 11 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 _____, 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 review and interview, the facility failed to ensure that medication observation records (MORs) were updated immediately each time medications were given to three (Residents #8, #9, and #10). Additionally, the facility failed to ensure that MORs did not contain errors for one Resident (#8). Furthermore, the facility failed to ensure that directions of use were noted on MORs for one (Resident #10) of seven sampled residents that required assistance with self-administration of medications. Findings Included: A record review for Resident #8, conducted on _____, revealed that Resident #8 was admitted to the facility on _____. According to Resident #8's health assessment form dated _____, the resident required assistance with self-administration of medications. Resident #8's MORs had prescribed medications that were not documented as given to the resident which included _____ 12.5mg dose and _____ 25mg dose. The medication _____ was misspelled as Sertaline for both doses. _____ 25mg take a half tablet every day for seven days was not documented as given from _____ through _____ and _____ through _____ at 08:00am. _____ 25mg take one full tablets every day was not documented as	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 12 given on and at 08:00am. A record review for Resident #9, conducted on, revealed that Resident #9 was admitted to the facility on, According to Resident #9's health assessment form dated, the resident required assistance with self-administration of medications. Resident #9's MORs had prescribed medications that were not documented as given to the resident which included 40mg on at 06:00am and at 08:00pm, 1 Gram on at 08:00pm, and 5mg on at 08:00pm. A record review for Resident #10, conducted on, revealed that Resident #10 was admitted to the facility on, According to Resident #10's health assessment form dated, the resident required assistance with self-administration of medications. Resident #10's MORs had a prescribed medication that was not documented as given to the resident which included 20mg on at 06:00am. Resident #10's MORs noted 1% 2 Gram Patch apply to affected area four times every day. The affected area to treat was not noted. Resident #10's MORs noted 0.77% Cream apply to affected twice every day. The specific or for the specific was not noted on the MORs. During an interview with the Wellness Director, conducted on at 03:00pm, the Wellness Director agreed that Residents #8, #9, and #10's MORs had medications that were not documented as given to the residents. The Wellness Director agreed that was misspelled on Resident #8's MORs. The Wellness Director agreed that the affected areas	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 13 were not noted on Resident #10's MORs for the medications Patch and Cream. Class III	A 054			
A 056 SS=D	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	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 14 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, faxed, or electronic copy of a medication order issued and signed by 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	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 15 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., 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, the facility failed to provide prescribed medications as ordered from residents' health care providers and failed to notify the residents' health care providers that residents did not receive their medications as prescribed for seven (Residents #2, #3, #7, #8, #9, #10, and #11) of seven sampled resident that required assistance with self-administration of medications. Findings Included: During a medication pass observation with Staff A for Resident #3, conducted on _____ from 10:52am through 10:57am, Staff A provided Resident #3 with the prescribed 08:00am medications Diltazem 90mg, _____ 100mg, _____ 10mg, _____ 500mg, Rivastigine 1.5mg, _____ 100mg, and _____ D3 5000. During an interview with Staff A, conducted on _____ at 10:58am, Staff A stated that Residents #2, #7, #8, #9, #10 and #11 had not received their scheduled 08:00am yet. Staff A	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 16 stated that the facility usually had three unlicensed Medication Technicians on duty but had two during the survey. During interviews with Residents #7, #8, #9, #10, and #11, conducted on _____ from 11:05am through 11:25am, Residents #7, #8, #9, #10, and #11 stated that they had not received their prescribed 08:00am medications during survey. A record review for Resident #2, conducted on _____, revealed that Resident #2's admission date was not noted in the resident's record. According to Resident #2's health assessment form dated _____, revealed that the resident required assistance with self-administration of medications. Resident #2's MORs had medications that were documented as not given to the resident which included _____ 40mg, _____ 100mg, _____ 60mg, _____ 5mg, _____ 5mg, _____ 40mg, _____ 500mg, Ensure Dietary Supplement, and _____ due to the resident's refusals. There was no evidence that the facility notified Resident #2's primary care provider or responsible party that the resident did not receive the medications as prescribed. Resident #2's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:31am on _____. A record review for Resident #3, conducted on _____, revealed that Resident #3 was admitted on _____. According to Resident #3's health assessment form dated _____, revealed that the resident required assistance with self-administration of medications. Resident #3's MORs had medications that were documented as not given to the resident which	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE CLUB AT HAINES CITY

**301 PENINSULAR DRIVE
HAINES CITY, FL 33844**

(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 056	Continued From page 17 included stockings due to the resident's refusals or other. There was no evidence that the facility notified Resident #3's primary care provider or responsible party that the resident did not receive the stockings as prescribed. Resident #3's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:02am on A record review for Resident #7, conducted on, revealed that Resident #7 was admitted on According to Resident #7's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #7's MORs had medications that were documented as not given to the resident which included 40mg, ... 12.5, ... 0.4mg, ... 0.5mg, and 5/235mg due to the resident's refusals. There was no evidence that the facility notified Resident #7's primary care provider or responsible party that the resident did not receive the medications as prescribed. Resident #7's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:24am on A record review for Resident #8, conducted on, revealed that Resident #8 was admitted on According to Resident #8's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #8's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:05am on A record review for Resident #9, conducted on	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 18 , revealed that Resident #9 was admitted on, According to Resident #9's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #9's MORs had medications that were documented as not given to the resident which included Tears due to the resident's refusals or other. There was no evidence that the facility notified Resident #9's primary care provider or responsible party that the resident did not receive the medication as prescribed. Resident #9's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:09am on A record review for Resident #10, conducted on, revealed that Resident #10 was admitted on, According to Resident #10's health assessment form dated, revealed that the resident required assistance with self-administration of medications. Resident #10's MORs had medications that were documented as not given to the resident which included 120mg, ... 25mg, ... 10mg, Diclogenic Patch, ... Cream, ... Cream, ... 5mg, ... 100mg, and 50mg due to the resident's refusals. There was no evidence that the facility notified Resident #10's primary care provider or responsible party that the resident did not receive the medications as prescribed. Resident #10's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:31am on A record review for Resident #11, conducted on, revealed that Resident #11's MORs had medications that were documented as not given to the resident which included	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 056	Continued From page 19 200mg, _____ 1mg, _____ 1000mg, _____ 2mg/5ml Syrup, and _____ 1.5mg due to the resident's refusals. There was no evidence that the facility notified Resident #11's primary care provider or responsible party that the resident did not receive the medication as prescribed. Resident #11's electronic MORs had a timestamp that the resident received prescribed 08:00am medications at 11:36am on _____. During an interview with the Wellness Director, conducted on _____ from 03:00pm through 03:18pm, the Wellness Director reviewed the times stamps for Residents #2, #3, #7, #8, #9, #10, and #11 and the Wellness Director agreed that the residents received their 08:00am scheduled prescribed medications was given outside of the timeframe to give residents their medications no more that one hours before or one hour after a medication was scheduled. The Wellness Director was not able to provide evidence that Residents #2, #3, #7, #8, #9, #10, and #11 primary care providers or responsible parties were notified that they did not received medications as prescribed. During an interview with the Administrator conducted on _____ at 02:30pm, the Administrator stated that medications were to be given no more than one hour before the scheduled time and no more than one hour after the medications was scheduled. Class III	A 056		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 152	Continued From page 20 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (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: 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 height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (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 This Statute or Rule is not met as evidenced by: Based on observation, record review, and	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964850	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2024
NAME OF PROVIDER OR SUPPLIER THE CLUB AT HAINES CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 301 PENINSULAR DRIVE HAINES CITY, FL 33844		
(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 152	Continued From page 21 interview, the facility failed to ensure that carpets were clean and decent throughout the facility. Findings Included: During observations of the carpeting through three of four hallways, conducted on at 10:45am, the carpeting appeared worn with tears and frayed areas. The Carpeting had many brown stains on each hallway which included but was not limited to in front of rooms A33, 37, 43, and the janitor's room.(photographic evidence obtained). During an attempt to review floor replacement services in process, conducted on , none were provided. During an interview with the Administrator, conducted on at 03:15pm, the Administrator stated that cleaning the carpets was pointless and would not remove the stains anymore. The Administrator agreed that the carpets needed to be replaced and were unsightly. Class III	A 152			