

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(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 An unannounced Relicensure survey and Generator Monitoring survey were conducted on at Tropical Garden Villas North. The facility had deficiencies identified related to the Relicensure survey at the time of the visit.	A 000			
A 010	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	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: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(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: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(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: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(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: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(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, it was determined that the facility failed to ensure a resident's Health Assessment form (AHCA form 1823) was updated every 3 years and / or upon significant health changes for 2 of 4 sampled residents reviewed (Residents # 8 and 9). The findings included: 1.) Record review of Resident # 8's Health Assessment form revealed it was signed and completed by the healthcare provider on . Further review of the file revealed no further documentation. During an interview with the Administrator on at 3:40 pm, Resident # 8's AHCA form 1823 was requested. He stated the facility does not have an updated AHCA Form 1823, he confirmed the last assessment was completed on . 2.) Record review of Resident # 9's Health Assessment form revealed it was signed and completed by the healthcare provider on . Further review of the file revealed no further documentation. During an interview with the Administrator on at 3:40 pm, Resident # 9's AHCA form 1823 was requested. He stated the facility does not have an updated AHCA Form 1823, he confirmed the last assessment was completed on . Class III	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 5	A 025		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____, _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 025	Continued From page 6 (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain a written record of significant health changes and notify the resident's primary care provider of significant changes, for 1 of 4 sampled residents reviewed (Resident # 9). Findings included: Review of Resident # 9's file revealed an admission date of Further review revealed the Resident Health Assessment Form (AHCA form) completed on with a noted diagnosis of (Type 2), and require medication assistance. An interview on at 3:25 pm with Staff B (caregiver) he stated that the resident checks her readings in his presence in the Medication room and documents on the facility form, entitled	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 7 Tropical Gardens North Vital Sign Flow Sheet. The form was requested for review. On _____ at 3:00 pm review of Tropical Gardens North Vital Sign Flow Sheet showed multiple high _____ (sugar) readings, above 150 mg/DL: On _____ 230 mg/DL On _____ 160 mg/DL On _____ 177 mg/DL On _____ 261 mg/DL On _____ 226 mg/DL On _____ 201mg/DL On _____ 220mg/DL On _____ 248mg/DL On _____ 271 mg/DL During an interview with Staff B at 3:25 pm he stated that he reported it to the Fact Team. However, he does not have any documentation showing that the Resident's health care provider was notified. Class III	A 025		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(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 078	Continued From page 8 when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(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 078	Continued From page 9 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility had no evidence that 3 of 3 sampled staff had a written statement from a licensed health care provider on file, and/or is missing _____ exam (Staff C, F, and B). Findings include: 1) On _____ at 3:25 pm a personnel record review revealed that Staff C (Administrator) date of hire was _____, had no evidence of a written statement completed by a health care provider that they were free of communicable _____ (_____). Futher review revealed that Staff C did not have any evidence of an annual negative _____ examination since 2009. 2) On _____ at 3:25 pm a personnel record review revealed that Staff F (Administrator Assistant) date of hire was _____, had no evidence of a written statement completed by a health care provider that they were free of communicable _____ (_____).	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(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 078	Continued From page 10 (). Futher review revealed that Staff F did not have any evidence of an annual negative () examination since the date of hire. 3) On at 3:25 pm a personnel record review revealed that Staff B (Medication Technician) date of hire was last () examination was on Futher review revealed that Staff B had missing an annual negative test for the year of 2022, 2023 and 2024. During interview with Staff C (Administrator) he stated that he taught all staff including himself were updated with . . . examinations. Class III	A 078		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND (). A staff member who has completed courses in First Aid and . . . and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform . . . and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(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 083	Continued From page 11 for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on employees record review and staff interview, the facility failed to ensure that at least a Staff member per shift held a current valid First Aid card documentation on file. Futher interview revealed that Staff B, C and F did not have any current valid First Aid cards on file. The findings included: Staff B, Medication Technician hired on did not have First Aid documentation on file. Staff C, the Administrator hired on did not have First Aid documentation on file. Staff F, the Administrator Assistant hired on did not have First Aid documentation on file. On at 3:35 PM, during interview with Staff C (Administrator), he was informed they were missing First Aid documentations for himself, Staff B, and Staff F. Class III	A 083			
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 084	Continued From page 12 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for _____ control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 084	Continued From page 13 accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and _____ dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with _____; j. Use a _____ to perform _____ testing; k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____ levels; l. Apply and remove _____ stockings and hosiery; m. Placement and removal of _____, bags, excluding the removal of the _____ or manipulation of the _____ site; and,	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 084	Continued From page 14 n. Measurement of _____ rate, temperature, and _____ rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Medication Technician (Staff B), and the Administrator (Staff C), had the required 6 hours initial training, and the 2 hours of	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 084	Continued From page 15 continuing education every year, on file, to assist with the self-administration of medication. The findings include: Record review and interview on _____ at 4:00 PM, revealed that Staff B and Staff C are missing the initial 6 hours training prior to assisting with self administration of medication. Staff B and Staff C are also missing the 2 hours of continuing education every year. Further review indicated that Staff C's last 2 hours training was _____. Medication Technician (Staff B's) last 2 hours training was on _____ Class _____	A 084		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. _____, 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance _____, 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 16 (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff,	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 162	Continued From page 17 or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TROPICAL GARDEN VILLAS NORTH

**420 CRESCENT CIRCLE
LAKE PARK, FL 33403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 18 arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that all residency contracts agreement were current and reflective of the current rental monthly rate, for 2 of 3 sampled contract reviewed (Residents #1 and #8). Findings included: Review of the residency contracts for Residents #1 and #8 revealed the following. 1) Resident #1 and Resident # 8's contract agreement revealed a monthly rental rate of \$1800. However, during an interview with the Administrator (Staff C) on _____ at 3:20 PM, he stated the rate had increased to \$2500 per month but he stated he has not had the time to update the residents' contract agreement. Further interview with Staff C, revealed all of the residents' contract agreement required updates. Class	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER TROPICAL GARDEN VILLAS NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESCENT CIRCLE LAKE PARK, FL 33403			
(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