Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days to the Agency for Healthcare Administration (AHCA) after a resident experienced a that resulted in a and transfer to a hospital for 1 of 9 sampled residents (#16.) Findings: Review of resident #16's record revealed a facility admission date of . The resident's medical history included and 's . The resident ambulated independently and needed supervision with transferring. On at approximately 11:17 pm the resident's roommate came out of their room and said this resident out of bed. The responding staff observed this resident laying in her bed. The resident confirmed she out of bed, hit her then got herself up and into bed. Emergency medical services ( ) was called and upon their arrival talked with the resident's family, who agreed to the resident not being transported to a hospital.	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 4 An post- investigation note for the indicated the resident said she reached down to grab something and over. A was placed on her bed. On at approximately 5:04 pm the resident had an unwitnessed . The camera footage revealed the resident was ambulating through the common area and appeared to hold on to another resident's . That resident walked towards their own apartment when this resident followed them. This resident then appeared to backwards, land on her right side then roll onto her . was called and after speaking with the resident's family the decision was made not to transport the resident to a hospital. , , services were ordered on but were delayed due to insurance issues. On at approximately 4:45 pm the resident was seen by staff running then into the activity area. The camera footage revealed the resident jogging into the common area when she runs into and trips over the ‿ of a chair then to her right side. On at approximately 8:10 am the resident was observed sitting on the floor in the common area with her ‿ outstretched. A post- investigation note indicated she attempted to throw away a cup and missed the trash can. When she squatted down to pick it up, she over to her right side. On a care meeting was held with the resident's family. The memory care director informed the family that the facility had a standard license and did not provide one on one supervision or monitoring of residents. The	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 5	CZ821		

memory care director discussed the mitigations put in place to help reduce the risk of falling including: pending , , services due to insurance, hospital evaluations, health care provider evaluations with medication review and changes, environmental review of apartment with no hazards identified, in place on bed, encouragement of activity participation and level of service evaluated to ensure proper staff assistance with activities of daily living (ADLs.)

On at 9:45 am the memory care director documented the resident was walking towards the dining room when she lost her balance and . She was not complaining of , and was assisted up. When the family was notified, their reply was "tell her to sit down for today." Approximately an hour and a half later, the resident was rubbing her left ˬ and complaining of , . She stood up but was unable to hold her own ˬ and . was called and she was transported to a hospital. The family later informed the facility the resident broke her left , .

A pos- investigation note for the first on indicated the resident was ambulating around the common areas after breakfast. She was standing in front of the dining room when the food cart was being moved and she attempted to move over, lost her balance then on her left side. She was not complaining of , and was assisted up. She would not place any ˬ on her left ˬ and was assisted to a chair.

A post- investigation note for the second on indicated camera footage showed the resident was sitting in a chair in front of the memory care manager's office when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 6 attempted to get up. She lifted herself up with her , was unable to hold her body ⌄ up with her ⌄ then to her left side. On at 9:33 am, the memory care director said the resident never received , ⌄ services due to her insurance. The memory care director said the family said they would change the insurance but never did. A request was made by the agency for healthcare administration (AHCA) surveyor to review the resident's service plan. Review of the only service plan provided revealed "unsteady gait/ risk" was "N/A." On at 10:50 am, the AHCA surveyor viewed the camera footage of the second . On at 9:56 am the resident was sitting in a chair located between the dining room and the activity room on the second floor. The resident used her to push herself up and out of the chair. She remained in a crouched position while bouncing up and down. She then fully stood, took one step on her left ⌄ then immediately on the floor. Caregiver L appeared in view from the direction of the dining room. Shortly thereafter, the memory care director then caregiver M arrived on scene. When arrived at 10:08 am they assisted the resident off the floor then to the chair. The resident limped while assisted her on the stretcher. On at 11:39 am, caregiver L said that when the resident the second time on she was cleaning up the dining room after breakfast. She turned her for one second to give the cart to the kitchen staff when she heard a scream. She turned around and saw the resident on the floor. The caregiver said the resident liked to stand up and would not sit down when told to	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 7 do so. The caregiver said the resident normally followed the staff around. The caregiver said the resident did not complain of , until after the second when she said her , hurt. On at 12:15 pm, the AHCA surveyor viewed the camera footage of the first . On at 8:18 am the resident was standing in the dining room. Caregiver L was standing nearby. A kitchen employee pushed the food cart past the resident's right side. The resident stumbled to the left and onto her left side to the floor. Caregiver M entered the dining room and she and caregiver L stood the resident up and walked her out of the dining room towards the area she was seen sitting during the second . As they were walking the resident was limping. On at 12:50 pm, caregiver M said when the resident the first time, she did not call a nurse because she was busy. She said after the first the resident was placed in the chair she was seen falling from during the second . The caregiver said the resident said she was okay when she in the dining room. The caregiver said she did not see the second . She said the resident did not normally follow directions and just got up and walked when she wanted. On at 1:02 pm, the memory care director said she was not in the facility when the resident the first time in the dining room and that neither caregiver L nor caregiver M called her. The memory care director said it was she who called after the second . She said the caregivers were permitted to get a resident off the floor after they obtain approval from a nurse or the person on-call at the time. She said the resident would not have remembered she was	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 8 told to stay seated, that she will but only for a little while, before getting up. On at 1:10 pm, the AHCA surveyor asked the administrator for a copy of the camera footage for both . The administrator said he had to check with someone else before allowing release of the footage. On at 1:13 pm, caregiver L said that after the first the resident's family member told her to tell the resident to sit down for the rest of the day. The caregiver said the resident denied hitting her after the first and had no complaints, so she and caregiver M picked the resident up and placed her in the chair. Caregiver L said the facility's protocol was that if a caregiver did not see a resident hit their or if the resident denied hitting their , the caregivers were allowed to get the resident off the floor. Caregiver L said the caregivers were required to call a supervisor, so she told the memory care director about the first when the director arrived at work that day, which was approximately two hours later. The facility's undated incident management and report policy and procedure defined an incident as any occurrence that is inconsistent with routine operations, routine service of a resident, any unexpected event involving a resident, staff member, visitor, equipment or when a situation varies from established policy or procedure and may lead to an undesired effect. All incidents or adverse incidents occurring in the community or on community property must be reported immediately to the executive director, resident care manager or memory care manager who will complete documentation utilizing the incident report form. All incidents or adverse incidents are	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	Continued From page 9 investigated to assure appropriate actions are taken to reduce potential reoccurrence and/or reduce risk of injury. On at 2:55 pm, the memory care manager, who was the on-call person on , said no one called her when the resident the first time. When this was told to the administrator, he showed the AHCA surveyor a call received from caregiver M on the on-call phone on at 8:20 am. On at 2:22 pm, the administrator said he and the home office would not release a copy of the footage to the surveyor. On at 2:40 pm, the AHCA surveyor requested the preliminary and full reports submitted to AHCA when the resident was sent to the hospital following the and , . The administrator replied that he did not submit the reports "because we didn't believe there was anything we could've done to prevent the ." Unclassified	CZ821		
A 000	Initial Comments A complaint investigation #2025000631, # 2025001185, #2025001232, #2025000740, #2025001241, #2025001410 and generator monitoring was conducted at Grand Villa of Altamonte Springs from - . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 10 429.26 (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. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 11 (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 observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for with injuries for 1 of 9 sampled residents (#16) and failed to document a delay in the start of home health care and to notify a health care provider of the delay for 1 of 9 sampled residents (#2.) Findings: 1. Review of resident #16's record revealed a facility admission date of . The resident's medical history included and 's . The resident ambulated independently and needed supervision with transferring. On at approximately 11:17 pm the resident's roommate came out of their room and	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 12 said this resident out of bed. The responding staff observed this resident laying in her bed. The resident confirmed she out of bed, hit her then got herself up and into bed. Emergency medical services ( ) was called and upon their arrival talked with the resident's family, who agreed to the resident not being transported to a hospital. An post- investigation note for the indicated the resident said she reached down to grab something and over. A was placed on her bed. On at approximately 5:04 pm the resident had an unwitnessed . The camera footage revealed the resident was ambulating through the common area and appeared to hold on to another resident's . That resident walked towards their own apartment when this resident followed them. This resident then appeared to backwards, land on her right side then roll onto her was called and after speaking with the resident's family the decision was made not to transport the resident to a hospital. , , services were ordered on but were delayed due to insurance issues. On at approximately 4:45 pm the resident was seen by staff running then into the activity area. The camera footage revealed the resident jogging into the common area when she runs into and trips over the ˬ of a chair then to her right side. On at approximately 8:10 am the resident was observed sitting on the floor in the common area with her ˬ outstretched. A post- investigation note indicated she	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 13 attempted to throw away a cup and missed the trash can. When she squatted down to pick it up, she over to her right side. On a care meeting was held with the resident's family. The memory care director informed the family that the facility had a standard license and did not provide one on one supervision or monitoring of residents. The memory care director discussed the mitigations put in place to help reduce the risk of falling including: pending , , services due to insurance, hospital evaluations, health care provider evaluations with medication review and changes, environmental review of apartment with no hazards identified, in place on bed, encouragement of activity participation and level of service evaluated to ensure proper staff assistance with activities of daily living (ADLs.) On at 9:45 am the memory care director documented the resident was walking towards the dining room when she lost her balance and . She was not complaining of , and was assisted up. When the family was notified, their reply was "tell her to sit down for today." Approximately an hour and a half later, the resident was rubbing her left ‿ and complaining of , . She stood up but was unable to hold her own ‿ and . was called and she was transported to a hospital. The family later informed the facility the resident broke her left , . A pos- investigation note for the first on indicated the resident was ambulating around the common areas after breakfast. She was standing in front of the dining room when the food cart was being moved and she attempted to move over, lost her balance	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 14	A 025		

then on her left side. She was not complaining of , and was assisted up. She would not place any ˬ on her left ˬ and was assisted to a chair.

A post- investigation note for the second on indicated camera footage showed the resident was sitting in a chair in front of the memory care manager's office when she attempted to get up. She lifted herself up with her , was unable to hold her body ˬ up with her ˬ then to her left side.

On at 9:33 am, the memory care director said the resident never received , , services due to her insurance. The memory care director said the family said they would change the insurance but never did. A request was made by the agency for healthcare administration (AHCA) representative to review the resident's service plan.

Review of the only service plan provided revealed "unsteady gait/ risk" was "N/A."

On at 10:50 am, the camera footage was viewed of the second . On at 9:56 am the resident was sitting in a chair located between the dining room and the activity room on the second floor. The resident used her to push herself up and out of the chair. She remained in a crouched position while bouncing up and down. She then fully stood, took one step on her left ˬ then immediately on the floor. Caregiver L appeared in view from the direction of the dining room. Shortly thereafter, the memory care director then caregiver M arrived on scene. When arrived at 10:08 am they assisted the resident off the floor then to the chair. The resident limped while assisted her on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 15 stretcher. On at 11:39 am, caregiver L said that when the resident the second time on she was cleaning up the dining room after breakfast. She turned her for one second to give the cart to the kitchen staff when she heard a scream. She turned around and saw the resident on the floor. The caregiver said the resident liked to stand up and would not sit down when told to do so. The caregiver said the resident normally followed the staff around. The caregiver said the resident did not complain of , until after the second when she said her , hurt. On at 12:15 pm, the camera footage was viewed of the first . On at 8:18 am the resident was standing in the dining room. Caregiver L was standing nearby. A kitchen employee pushed the food cart past the resident's right side. The resident stumbled to the left and onto her left side to the floor. Caregiver M entered the dining room and she and caregiver L stood the resident up and walked her out of the dining room towards the area she was seen sitting during the second . As they were walking the resident was limping. On at 12:50 pm, caregiver M said when the resident the first time, she did not call a nurse because she was busy. She said after the first the resident was placed in the chair she was seen falling from during the second . The caregiver said the resident said she was okay when she in the dining room. The caregiver said she did not see the second . She said the resident did not normally follow directions and just got up and walked when she wanted. On at 1:02 pm, the memory care director	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 16	A 025		

said she was not in the facility when the resident the first time in the dining room and that neither caregiver L nor caregiver M called her. The memory care director said it was she who called after the second . She said the caregivers were permitted to get a resident off the floor after they obtain approval from a nurse or the person on-call at the time. She said the resident would not have remembered she was told to stay seated, that she will but only for a little while, before getting up.

On at 1:10 pm, the administrator was asked for a copy of the camera footage for both . The administrator said he had to check with someone else before allowing release of the footage.

On at 1:13 pm, caregiver L said that after the first the resident's family member told her to tell the resident to sit down for the rest of the day. The caregiver said the resident denied hitting her after the first and had no complaints, so she and caregiver M picked the resident up and placed her in the chair. Caregiver L said the facility's protocol was that if a caregiver did not see a resident hit their or if the resident denied hitting their , the caregivers were allowed to get the resident off the floor. Caregiver L said the caregivers were required to call a supervisor, so she told the memory care director about the first when the director arrived at work that day, which was approximately two hours later.

The facility's undated incident management and report policy and procedure defined an incident as any occurrence that is inconsistent with routine operations, routine service of a resident, any unexpected event involving a resident, staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 17	A 025		

member, visitor, equipment or when a situation varies from established policy or procedure and may lead to an undesired effect. All incidents or adverse incidents occurring in the community or on community property must be reported immediately to the executive director, resident care manager or memory care manager who will complete documentation utilizing the incident report form. All incidents or adverse incidents are investigated to assure appropriate actions are taken to reduce potential reoccurrence and/or reduce risk of injury.

On at 2:55 pm, the memory care manager, who was the on-call person on , said no one called her when the resident the first time. When this was told to the administrator, he showed a call received from caregiver M on the phone on at 8:20 am.

On at 2:22 pm, the administrator said he and the home office would not release a copy of the footage of the two resident #16 had on .

2. On at 10:05 am, resident #2 was seen sitting in a wheelchair in his room. A gauze was seen wrapped around his right . He said that since his return from the hospital on the was changed by a home health nurse a total of only two times and once by the facility's resident care manager. He said the hospital's instructions were to change it three times a week. He said the was last changed on .

Review of resident #2's record revealed a facility admission date of . The resident's medical history included , , and right complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 18 , . A health assessment form (1823) indicated the resident had lower extremity , , ◡ and a . On at approximately 11:20 am the resident's power of attorney (POA) informed a facility nurse that was in route to the facility. The POA said the resident was experiencing extreme , in his right ◡ and needed emergency services. arrived and the resident was ultimately sent to a hospital. On at 9:45 am the resident care manager documented the resident was receiving ( ) for a and lymphedema . , to both ◡ while at the hospital. On at approximately 2:23 pm the resident returned to the facility. A health care provider ordered home health for a right lower extremity . There was no documentation in the resident's record to indicate the order was forwarded to a home health agency. On a ◡, provider performed a -to- examination and ordered a home health nurse to cleanse the three times a week, apply ◡ ◡ and 4x4 ◡. During the examination the resident reported the was draining and painful. There was no documentation in the residents' record to indicate the orders were forwarded to a home health agency. The facility's third-party services policy and procedure, created , indicated that when the community is aware that third party services are being provided or recommended for the resident,	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 19	A 025		

the community must document any assistance provided in the coordination of these services. For example, when a physician order is received, a copy of the order and any fax confirmations must be placed in the residents' record.

A home health start of care note, fourteen days after the resident's return from the hospital, indicated the right 's edges were rolled, there was a moderate amount of with moderate odor and partial maceration of the surrounding tissue.

There was no documentation in the residents' record to indicate the reason for the delay in starting home health and no documentation to indicate the health care provider was notified of the delay.

On at 1:55 pm, a home health registered nurse removed the gauze so the could be seen by the AHCA representative. The measured approximately 1 cm x 0.5 cm. The was superficial. The bed was pink and moist. There were no visible signs of . The resident said the occurred because of his , then he hit it against something, causing an opening in the skin.

On at 3:32 pm, the resident care manager said she changed the on by replacing the 4x4 gauze and gauze wrap and did so because the resident was angry that home health had not seen him yet. There was no documentation in the residents' record of the change, the condition of the at that time and no documentation of the resident's anger and any follow-up to this. The resident care manager went on to say the delay in home health starting was because the home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 20 health agency required a -to-examination by a health care provider before the start of service. The resident care manager said she did not document her own care, including her observations of the 's condition. When asked why, she replied "I just didn't, and I just got on with my life." Class II	A 025		
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;	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 21 for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by 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,	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 22 and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., 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 reviews and interviews, the facility failed to ensure medications were refilled in a timely manner to ensure doses were not missed for 1 of 9 sampled residents who required assistance with self-administration of medications (#10). Findings: On at 9:35 am, observation during a med pass revealed unlicensed caregiver A preparing and providing assistance with self-administration of medication But/ , , /CAF Tab /40 take 2 tablets by twice a day to resident #10. A review of resident #10's record revealed a facility's admission date on . A 1823 health assessment form indicated a medical history of	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 23 failure ( ), , , ( ), , , , ( ), acute , injury, , , , ( ), and needs assistance with self-administration. A review of resident #10's , Medication Observation Record (MORs) indicated as needed But/ , /CAF Tab 50 /325/40 take two tablets (100- 650 - 80mg) by twice a day as needed for revealed a dash and did not reflect staff initials as administered. A review of resident #10's , Medication Observation Record (MORs) indicated , , and as needed But/ , /CAF Tab 50 /325/40 take two tablets (100- 650 - 80mg) by twice a day as needed for revealed a dash and did not reflect staff initials as administered. Furthe review of the and MORs charting codes select reasons for a dash indicated out of building, out with family, other problems, no pass per vitals, refused by resident, and meds not available. A review of resident #10's observation notes from - , the report provided did not reveal any observation notes were documented of the missed medication from - or results of not having it. On at 10:06 am, resident #10 stated, I didn't have any issues with my other medications. It was just my meds But/ , /CAF Tab that I didn't have. Resident #10 stated the facility said it was only 3 -4 days that I didn't have it, but it felt like a week. It was ridiculous that I had to wait so long. The staff was letting me know of the delay	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 24 in my meds and I was advised to change to an in-house doctor. A review of the medication cart located in the 300 building which stored resident #10's But/ , , /CAF Tab 50 /325/40 revealed a filled date on . . . on the bubble pack. A review of the facility's updated Medication Refills Policy and Procedure stated, it is the policy of the Community to process medication refill requests within a reasonable timeframe to promote reductions in medication interruptions. The Resident Care Manager, Memory Care Manager, and/or Designee are responsible for ensuring medication refill orders are requested in a timely manner. A refill request is to be completed by the Medication Technician when medications reach the alert quantity below: pharmacy alert quantity = 7-day supply, and responsible party alert quantity= 7-day supply. Preferred pharmacy refills: requests must be submitted electronically in the eMor system. Responsible party requests: request the refill by phone or email, document the request in the resident's chart as an observation, place a copy of the request in the pending order file, and include the date and time of the request and your initials. Each Medication Technician is responsible for ensuring medication refills are received timely for their assigned residents through daily reviews of the eMOR refill order system and pending order file. at 1:33 pm, unlicensed caregiver A stated, this medication referring to But/ , , /CAF Tab 50 /325/40 is PRN (as needed). So, when resident #10 ask for it. We give it. She always asked for it during the med pass. When she didn't have it for the 3 -4 days, we called caregiver G or	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 25 the nurse. You'll have to talk with caregiver G about the refills. We don't refill . I just tell the nurse and she will call the doctor to get a refill. We just continue to tell resident #10 we don't have it and that we've told caregiver G or the nurse. at 3:40 pm, the resident care manager stated caregiver G usually takes care of that (referring to the refills). I did see a note sent to the doctor for resident #10's refills. I will pull the log and provide for you to review. Review of resident #10's medication count log for But/ , , /CAF Tab /40 revealed the last pill was issued on at 8:30 pm. at 4:18 pm, the resident care manager provided a physician's order dated for resident #10's But/ , , /CAF Tab 50 /325/40 medication. She stated resident #10 switched providers from her primary to the facility's doctor. I'll have to contact the doctor to see when the switch occurred. On at 4:55 pm, the resident care manager (RCM) stated, resident #10 switched on to the new provider. She stated, caregiver G stated he reached out to the provider to come and visit resident #10. I'm not sure of the delay as there wouldn't have been. She started seeing the doctor on . She stated caregiver G is out today and will be in the office tomorrow to further explain. Resident #10 was asked if she had any negative side effects from not getting her medication from On at 9:04 am, resident #10 stated, I	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 26 was screaming for days because I had a and body ache due to not having my , medication. I switched to the facility doctor because I was told I would be able to get my medication quicker. I don't remember the staff who told me, but I think it was the resident care manager because I was in her office. So, maybe it was her and caregiver G. At that time, I had a different doctor, and I made several calls to him to get a refill, but he didn't respond. So, that's when I switched. Caregiver G was asked for the documentation of resident #10's medication refill. On at 12:12 pm, Caregiver G stated, assuming resident #10 can get that medication twice a day. We have a reorder button on the computer, staff normally alerts me when a resident is running low. For resident #10, the staff verbally told me towards the end of , I did not document any of the information in her chart. I reached out to the pharmacy to get the medication reordered. A day passed, so I reached out again to the pharmacy and was told resident #10 needed a new refill script because it was a . I reached out to all the nurses to make them aware resident #10 needed a new script. Assuming the nurses reached out to the provider, and at that time resident #10 wanted to switch to the doctor for the facility. The doctor stated they would not provide a refill until after they saw resident #10. The new Physician Associate (PA) saw her towards the end of , and that's when she signed a new script. Caregiver G reviewed the script dated stating, I thought she had a script dated earlier than after the PA's visit. I'm sure I saw it. Resident #10 had zero refills and at that time she wanted to switch over doctors, which prolonged	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910126	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 27 the wait. I didn't know the situation up until now that she did not have her medication. I didn't know the PRN medications were not auto refills and were allowing the staff to just tell me. So, now that I know, I will go and check to make sure the residents have their refills. I reached out to the pharmacy myself to ask for an emergency supply but because she needed a hard script for refills, they would not provide any pills. The facility failed to follow their medication refills policy and procedure ensuring resident #10 received her medication within the 7-day supply and failed to document in the resident's chart as an observation of the steps taken and delays. On at 2:23 pm, the Administrator confirmed the findings and provided no additional documentation. (photographic evidence obtained) Class III	A 056		