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
	AL11969201	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CHOICE DELTONA	2310 N NORMANDY BLVD DELTONA, FL 32725

(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
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their comprehensive emergency management plan (CEMP), used as guidance to support all residents during an emergency, to the local emergency management agency on an annual basis. The finding include: A record review on revealed that the last approval letter from the facility's local emergency management agency was dated . An interview was conducted with the Administrator at 12:50pm on . In the interview, she stated that she was not able to find any more recent CEMP submission or approval, and that the last approval received was . She did not believed there had been any submissions since then. Class III	CZ830		
A 000	Initial Comments A complaint investigation (2023011865, 2023011946,20230013920,2024000847,2024002255,2024002627, 2025000885,2025001764) with generator monitoring was conducted at Gold Choice Deltona on - . Deficiencies were identified at time of the survey.	A 000		

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A 025	Continued From page 3	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		

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A 025	Continued From page 4 (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 staff interview, the facility failed to maintain a written record documenting significant changes and contacting the resident's family/guardian for 2 of 3 residents reviewed. (Resident #2 and #4) The findings include: 1. Record review of the facility admission/discharge log revealed Resident #2 was admitted to the facility and discharged as on . Further record review found no evidence of what happened to the resident on . The last note found was dated . Durning an interview with the Resident Service Manager on at 10:40 AM, she stated the resident , , at the facility. She stated one day she was not feeling well. She was tired	A 025		

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A 025	Continued From page 5 and wanted to stay in bed. They checked her , that day and it was fine. The next day they checked on her and she was . She stated she did not have a written record of what happened. The findings were also confirmed by the Administrator on at 11:00 AM. She stated the facility did not have any record of what happened. 2. Record review of the facility's admission/discharge log revealed Resident #4 she was admitted to the facility on and discharged to a higher level of care on . A review of the resident record found a prescription for home health care to evaluate and treat a to the inner , and on . There were no other notes in the resident record. There was a Form 3008 found in the resident record with an illegible date completed by the resident's nurse practitioner. During a telephone interview with the nurse practitioner on at 11:00 AM, she stated she recalled the resident. She had her arm in a sling and had . She did not send her out. She received a call that she was being sent out. She did not know the date or reason, but it was around the same time as the order for . She did not contact the family. A review of the incident log provided by the facility found no incidents were documented for Resident #2 and #4. Class III	A 025		
A 170	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after	A 170		

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A 170	Continued From page 6 the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a timely refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident, for 2 of 2 residents reviewed for refunds (Resident #4 and #8). The findings include: 1. Record review of the facility admission/discharge log revealed Resident #4 was admitted to the facility on and discharged . Record review of the resident file found she went on therapeutic leave on . There was no evidence in the resident record of when the resident was discharged from the facility, the reason why, or when her belongings were removed. During an interview with the Administrator on at 10:00 AM, she confirmed the findings and stated she was assuming Resident #4's belongings were moved out of the facility on because that is the move out date in the facility's computer system. A review of the Residency Agreement for Resident #4 found it was signed by the resident's power of attorney (POA) on with a	A 170		

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A 170	Continued From page 7 beginning date of . . . Page 5 of 10 of the agreement under E Refund documented "You are entitled to a prorated refund of the service rate based on the monthly rate for any unused portion of payment beyond the established termination date after all charges, including the cost of damages to your apartment resulting from circumstances other than normal use have been paid. This refund shall be within 45 days of you vacating your apartment. In the case of or discharge due to medical reasons including mental health, the notice of termination requirements in the contract is waived and all refunds are prorated as of the date your apartment is vacated." The monthly amount of the contract was $3300.00 to income plus Medicaid, the amount that was actually paid is $2485.00. The resident pays $885.00, and Medicaid pays $1600. During further interview with the Administrator on at 12:20 PM. She stated they had to wait for the rest of the money to come in from Medicaid before the resident could be refunded the money she paid. She provided a copy of the check for a $885.00 refund to the resident's power of attorney showing the date on the check was . Photographic evidence obtained. 2. Record review of the facility admission/discharge log revealed Resident #8 was admitted to the facility on . . . and discharged to a higher level of care on . Record review of the resident record found the last notes documenting the resident was in the facility dated when the resident was found on the floor and sent to the hospital.	A 170		

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A 170	Continued From page 8 A review of the Residency Agreement for Resident #8 found it was signed by the resident's representative on with a beginning date of . Page 5 of 10 of the agreement under E Refund documented "You are entitled to a prorated refund of the service rate based on the monthly rate for any unused portion of payment beyond the established termination date after all charges, including the cost of damages to your apartment resulting from circumstances other than normal use have been paid. This refund shall be within 45 days of you vacating your apartment. In the case of or discharge due to medical reasons including mental health, the notice of termination requirements in the contract is waived and all refunds are prorated as of the date your apartment is vacated." The monthly amount of the contract was $3605.00. During an interview with the Administrator on at 9:05 AM she provided the refund check that was sent to the resident. It was in the amount of $5,225.31 and issued on . The findings were confirmed with the Administrator, she stated the check was issued on the 46th day. Photographic evidence obtained. Class III	A 170		