

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number: 2025007601) and a generator monitoring visit were conducted at Cherry Blossom Assisted Living Facility on . Deficiencies were identified at the time of survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately update the medication observation record each time medication were offered to one Resident (#1) of one sampled resident. Findngs included: A medication observation record review for Resident #1, conducted on _____, revealed that Resident #1 had medications that were not documented as given in _____ and which included the resident's prescribed medications _____ 5 milligrams (mg), _____ 10 mg, _____ 10 mg, _____ 5 mg, _____ 10 mg, _____ 0.25 mg, _____ D-2 50000 units, _____ 20mg/12.5 mg, _____ 20 milliequivalent, and _____ 1000 microgram (photographic evidence obtained). During an interview on _____ at 10:45 a.m. Staff A stated that the medication observation records provided for Resident #1 was all the resident had and there were no others. Class III	A 054		
A 120 SS=D	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the	A 120		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 120	Continued From page 2 facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain financial stability and was foreclosed upon. Findings included: A review of the letter dated _____ from the new landlord, conducted on _____, revealed that the residence of the assisted living facility was foreclosed on _____ and the tenants had to vacuate the premises on _____. In addition, the landlord demanded \$4000.00 payment for rent. During an attempt to review monthly rent bills due and paid from _____ through present day,	A 120		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 120	Continued From page 3 conducted on _____, the documents were not provided. A review of the cable and electric bill, conducted on _____, revealed that the amount owed on the cable bill due on _____ was \$223.90 which included a \$10.00 late fee and a past due balance of \$106.96. The cable bill was last paid on _____ and the amount did not include the current past due amount. The past due amount on the electric bill as of _____ was \$4487.13. A review of the facility's banking account, conducted on _____, revealed that the balance in the account was \$3385.47. During an interview on _____ at 11:00 a.m. the Administrator stated that the residents had been given a 45-day notice of residency termination dated _____ due to the foreclosure of the residence. The Administrator stated that she had not paid the rent for six months and she was unable to provide bills or payments for the rent due. At 11:51 a.m., the Administrator stated that Residents #1 and #2 would not be paying for residency for _____ and Resident #2 had not paid for _____. At 12:05pm, the Administrator stated that the facility did not have money to pay any other employees. The Administrator agreed that there were no funds coming into the facility for _____. Class III	A 120		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 161	Continued From page 4 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain	A 161			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 161	Continued From page 5 personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the facility maintained a personnel record for one employee (Staff A) of one sampled employee. Findings included: Observations of Staff A, conducted on from 10:17 a.m. through 12:30 p.m., Staff A was actively working in the facility to meet Resident #1 and Resident #2's needs. A review of the staffing schedule, conducted on , revealed that Staff A worked at the facility on Wednesdays and every other Saturday and Sunday. During an attempt to review Staff A's employee record, conducted on , Staff A's employee record was not provided. During an interview with Staff A, conducted on at 10:45am, Staff A stated that she helped out at the facility and did not have an employee record.	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 161	Continued From page 6 During an interview on _____ at 12:05 p.m. the Administrator verified that Staff A was one of three employees that worked at the facility. Class III	A 161		
A 162 SS=D	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. (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	A 162		

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 8 2005, 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 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,	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969634	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER CHERRY BLOSSOM ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2810 CHERRY TREE LN PLANT CITY, FL 33565		
(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 9 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, the facility failed to ensure that health assessments were obtained every three years and documented on the required _____ form for one Resident (#1) of two sampled residents. Findings included: A record review for Resident #1, conducted on _____, revealed that Resident #1 was admitted to the facility on _____. Resident #1's health assessment for dated _____ was on the _____ form and not the required _____ form. The assessment was completed greater than three years ago. During an interview on _____ at 11:00 a.m. the Administrator stated that she had requested an updated health assessment from Resident #1's primary care Provider but had not received it yet. The Administrator agreed that the form was greater than three years old. Class III	A 162		