

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER AMBIANCE AT MAITLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 740 NORTH WYMORE ROAD MAITLAND, FL 32751		
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CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the _____ are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective _____, or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before _____, initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person 's status has been made. 2. Effective _____, initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person 's status has been made.	CZ814			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person's full first name, middle initial, and last name; social security number; date of birth; mailing address; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, review of the Care Provider Background Screening Clearinghouse and interview, the facility failed to update the clearinghouse within 5 business days after 1 of 8 sampled staff (J) was hired. Findings: Review of caregiver J's personnel record revealed a hire date of On at 2:12pm, review of the care provider background screening clearinghouse revealed caregiver J was not listed. On at 2:30pm, a review of the clearinghouse revealed caregiver J was added on , which was the date of the survey. On at 5pm, the administrator said she updated caregiver J's employment status on the	CZ814			

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CZ814	Continued From page 2 clearinghouse after being asked by the surveyor to provide the personnel record. Unclassified	CZ814			
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/SingleSignOnPo rtal . 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:	CZ821			

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CZ821	Continued From page 3 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. 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:	CZ821			

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CZ821	Continued From page 4 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 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: https://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)	CZ821			

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CZ821	Continued From page 5 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 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 after law enforcement responded to the facility following an altercation between 2 of 20 sampled residents (7, 9). Findings: Review of resident #7's record revealed a facility admission date of . Review of resident #9's record revealed a facility admission date of . Both residents had a diagnosis of 's , and both lived in the secure memory care building. On at 1:23 PM, resident #9 reported to staff that resident #7 was in her room. Staff asked	CZ821			

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CZ821	Continued From page 6 resident #7 to leave the room at which time he began yelling. Resident #9 yelled at resident #7 to leave her room at which time resident #7 lunged at #9, grabbed her by the hair, then hit her in the . Staff separated them at which time resident #7 swung his fist at the staff. Staff were able to redirect resident #7 to his room without further incident. Resident #7 told staff resident #9 slapped him and said he did not remember hitting her. Resident #7's responsible party was notified. Local law enforcement was called to the facility based on a request to do so by resident #9's responsible party. When the responding law enforcement went to resident #7's room, he was in bed with his , closed. His responses were minimal, and he did not engage in conversation. On at 3:32 PM, the administrator said preliminary and full reports were not submitted after law enforcement responded to the facility because the family, and not the facility, called them. On at 2:40 PM, activities assistant O said she witnessed the incident between resident #7 and #9 on . The activities assistant said she tried to redirect resident #7 out of the room when he became agitated. Resident #9 then told resident #7 to get out. Resident #7 then hit #9 twice on her with a closed fist. Resident #9 did not suffer an injury. Resident #9's family called law enforcement. The activities assistant said she tried to prevent incidents with resident #7 by redirecting him the best that she can. She said resident #7 participated in some activities but oftentimes got up and walked away.	CZ821			
A 000	Initial Comments	A 000			

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A 000	Continued From page 7 A complaint investigation (2025004611, 2025006195, 2025006221) and a generator monitoring was conducted at Ambiance at Maitland on _____ and _____. The facility had deficiencies at the time of the survey.	A 000			
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on	A 004			

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A 004	Continued From page 8 contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to obtain prior approval from the field office when a portion of the licensed facility was changed to a secured memory care unit. Findings: On at 11:55 AM, eleven resident rooms were seen in a secure area on second floor of the assisted living building. Six residents were present. There was no documentation to indicate prior approval was obtained from the field office	A 004			

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A 004	Continued From page 9 when that area was converted into a secure memory care unit. On _____ at 4:50 PM, the administrator said that area was converted sometime during _____. She said when remodeling was done on the existing memory care building those residents were moved to the now secure second floor area. When the remodeling was complete the residents were moved _____ to the existing memory care building and the second-floor area remained secure. Class III	A 004			
A 010 SS=D	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private	A 010			

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A 010	Continued From page 10 residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility	A 010			

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A 010	Continued From page 11 to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.	A 010			

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A 010	Continued From page 12 (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within	A 010			

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A 010	Continued From page 13 the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on facility's documentation, resident record review and interview, the facility failed to obtain a new Agency for Healthcare Administration (AHCA) 1823 Health Assessment Form completed by a healthcare provider for 2 of 20 sampled residents (#6, #20) as required for a significant change and to continued residency. Findings: 1. A review of an incident reported on _____ at 12:45 PM that resident #6 was missing and eloped from the facility and found across a major road, across the street near some businesses parking lot at 2:45 PM (same day) by the facility's Cook that happened to take a walking break going that direction. Resident #6 was missing for about 2 hours from the facility. A review for resident #6's record revealed admission date _____. The last 1823 Health Assessment dated _____ listed medical history of _____ and _____. She needed only supervision in activities of daily living with bathing, eating and grooming. Independent with ambulation, _____, toileting and transferring. She was not an elopement risk prior to _____ and living in the assisted living	A 010			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
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A 010	Continued From page 14 side, not memory care. She need assistance with self-administration of medications daily. There was no documented evidence of a new 1823 Health Assessment completed by the healthcare provider found in the file. On at 4:59 PM, an interview with the Administrator confirmed the finding. (Photographic Evidence Obtained) On at 1:09 pm a record review of resident 20's chart revealed an admission date of . At 1:45pm request nurse's notes for resident 20, which revealed she had numerous . Resident 20's health assessment 1823 revealed she has no known drug , she has a medical diagnosis of , , , , , dyslipidemia and . History of : - No incident report was filed - No incident report was filed, (according to the nurse's note resident sustained a large hemotoma to the of her). - w/o higher level of care - w/o higher level of care , facility filed an incident report On at 4:19pm the wellness coordinator stated that the facility did nnot train or implement training for the employees, on how to prevent on resident 20. She also went on to say that the residents daughter request to take her mother off of hospice care. The wellness coordinator stated that about six weeks ago after resient 20 had	A 010			

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A 010	Continued From page 15 taken a on . The wellness coordinator went on to say that the daughter wanted her mother to be placed on . , to strenghten her mothers . . The wellness coordinator then stated once the daughter brought up the idea to hospice on abouthter mother getting , hospice denied her. On resident 20 was discharged from hospice care so resident 20 could get the nescessary . The wellness coordinaoor stated that the , , did not work due to the resident not being able to follow verbal cues being given by the physical therapist. Resident is appropriate for the facility. On at 11:35am request resident 20's care plan from the administrator. A review of resident 20's care plan it revealed that the facilityt failed to place interventions and set parameters to prevent resident 20 from falling. On at 5:14pm the administrator confirmed the , and also confirmed that the facility did fail to set safety parameters for resident 20. The administrator was reminded that once a resident had gone out for a higher level of care the residents primary care provider (PCP) needs to be notified and the health assesment 1823 form must be revised. Photographic evidence obtained. Class III	A 010			
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	A 025			

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A 025	Continued From page 16 429.26 (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			

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A 025	Continued From page 17 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, 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 2 of 12 sampled residents (16, 20.) Findings: 1. A review of two separate incidents for resident #16, the first incident reported on at 1 AM for a resulting injury and was sent to hospital. Review of the hospital records revealed resident #16 had sustained a to the right arm, a to the (region) and a to one on the left side. T confirmed by the hospital record. The second incident was reported on at 9 AM for another on at 3:40 PM in the common area of the assisted living facility, about 12 hours later after resident #16 had	A 025		

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A 025	Continued From page 18 returned from the hospital from the 1st . The report revealed resident #16's had moderate on the floor from the , and a to right side of . The first responders were called, and the daughter was notified. The daughter arrived at the facility before the first responders and declined to take resident #16 to the hospital to get checked even though the first responders recommended to do so. The daughter signed a waiver not to take her mother (resident #16) to the hospital and provided to it the first responders. A facility note on at 9:22 AM by the prior Director of Wellness documented resident #16 was found and observed in her bed, unresponsive. The prior Director of Wellness arrived at the room and observed resident #16 lying in a supine position in her bed, with agonal breathing. Resident #16 was not responding to verbal or stimuli, 911 was called. The physician and family were notified. Resident #16 was transported to the hospital. Resident #16's condition was reported to the first responders when they arrived, and the nurse said it would be better that resident #16 be sent out to another hospital because they were better equipped to handle various medical conditions. A facility note on at 12:27 PM by the prior Director of Wellness documented that she spoke with the daughter, according to the resident's daughter, resident #16 was admitted to the hospital. () for severe . The daughter stated resident #16 was a , so they are just going to make her comfortable because resident #16 was not going to make it. The daughter said that we will make arrangements to get her things from the facility and would call to give an update later. The	A 025			

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A 025	Continued From page 19 physician was notified. A facility note on _____ at 2:21 PM by Wellness Coordinator documented that she was informed by resident #16's daughter that resident #16, _____, this morning at 645 AM at the hospital. The daughter stated they would have resident's #16 personal belongings cleared out by Sunday, _____. There was no documented evidence of interventions put in place, and no documented evidence of increased supervision to prevent for resident #16 in the file. There was no service care plan for _____ prevention for resident #16 in the file. A review of resident #16's record revealed admission date _____. The last 1823 Health Assessment dated _____ listed medical history of _____ and _____. She had special precautions for being at high risk for and getting lost. She ambulated via wheelchair and needed assistance in activities of daily living with ambulation, _____, and eating. Supervision with grooming, toileting, and transferring. Independent with eating. Resident #16 was not on Hospice care and needed assistance with self-administration of medications. On _____ at 3:40 PM, an attempted telephone interview with unlicensed caregiver M, no answer. Left voicemail message. No returned call. On _____ at 4:59 PM, an interview with the Administrator confirmed the findings.	A 025		

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A 025	Continued From page 20 On at 8:30 AM, an attempted telephone interview with daughter. A voicemail message was left. There was no return call. On at 10:10 AM, another attempted telephone interview with daughter. A voicemail message was left. There was no return call. On at 10:15 AM, an attempted telephone interview with the prior Director of Wellness, no answer. A voicemail message was left. There was no return call. On at 10:20 AM, an attempted telephone interview with unlicensed caregiver I, no answer. A voicemail message was left. There was no return call. (Photographic Evidence Obtained) Class II 2. On during a records review of resident #20's chart revealed resident #20 sustained numerous History of : - No incident report was filed - No incident report was filed, (according to the nurse's note resident sustained a large hematoma to the of her). - w/o higher level of care - w/o higher level of care , facility filed an incident report A record review of resident 20's health	A 025			

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A 025	Continued From page 21 assessment record 1823 revealed an admission date of , her medical diagnosis revealed she has no known drug , she has a medical diagnosis of . Upon further review of her record, it was revealed she was not identified as a precaution. On at 4:19pm the wellness coordinator stated that the facility did not train or implement training for the employees on how to prevent . She also said the resident's daughter requested her mother be taken off hospice care. The wellness coordinator stated that about six weeks ago after resident 20 had taken a on , she went on to say that the daughter wanted her mother to be placed on , (), to strengthen her mother's . The wellness coordinator stated that when the daughter on approached hospice with the idea of her mother getting , hospice denied her. On resident #20 was discharged from hospice care so resident could get . The wellness coordinator stated that the , did not work due to the resident not being able to follow verbal cues. Resident was appropriate for the facility. On at 11:35am a request was made to review resident #20's care plan from the administrator. A review of resident 20's care plan revealed that the facility failed to place interventions and set prevention parameters to prevent resident #20 from sustaining multiple . On at 5:14pm the administrator confirmed the and confirmed that the facility failed to set safety parameters for resident #20.	A 025		

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A 025	Continued From page 22 (Photographic Evidence Obtained) Class II	A 025			
A 030 SS=G	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030			

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A 030	Continued From page 23 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030			

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A 030	Continued From page 24 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.	A 030			

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A 030	Continued From page 25 (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free	A 030		

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A 030	Continued From page 26 telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to	A 030			

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(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 030	Continued From page 27 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to honor resident rights and provide a safe living environment, free from resident-to-resident , for 4 of 12 sampled residents (7, 8, 9, 10.) Findings: Review of resident #7's record revealed a facility admission date of .	A 030			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMBIANCE AT MAITLAND

**740 NORTH WYMORE ROAD
MAITLAND, FL 32751**

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A 030	Continued From page 28 Review of resident #8's record revealed a facility admission date of . Review of resident #9's record revealed a facility admission date of . Review of resident #10's record revealed a facility admission date of . All the residents had a diagnosis of 's , and all lived in the secured memory care building. On at 11:20 AM resident #7 was observed in the courtyard with resident #8. Resident #7 was seen touching resident #8 with his . Both residents were redirected and escorted inside. A primary care physician (PCP) and a , physician were notified. was prescribed for resident #7 to decrease his desires. On at 11 AM resident #7 was observed in his room with resident #8, who was standing in the doorway with his exposed. Resident #8 was redirected out of the room. Resident #7's PCP and , physician were notified. Having a private sitter with resident #7 was recommended to his responsible party. On at 8:11 PM resident #10 was observed standing in front of the activity room door. Resident #7 walked up to resident #10 and told the resident to move. Resident #10 did not move so resident #7 hit #10 in the . A caregiver attempted to redirect resident #7 but he raised his fist. So instead, the caregiver redirected resident #10 to a common area. There were no injuries. Resident #7's PCP and responsible party were notified.	A 030		

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A 030	Continued From page 29 On _____, _____, and _____ resident #7 had a private sitter from 9 AM to 5 PM. On _____ at 11:30 AM resident #9 was observed walking down a hallway holding her _____ and screaming. Resident #7 was observed walking behind #9 hitting the resident on her _____. Resident #7 said he hit #9 because "she's not listening, so I had to do what I had to do." On _____ at 7 PM resident #7 was observed exiting resident #9's room. Prior to this, resident #9 was observed walking down a hallway yelling that resident #7 asked for a lighter for his cigarettes. Resident #9 told resident #7 she did not have one then resident #7 hit her in the _____. When a caregiver approached resident #7, he put a fist up. The caregiver asked him not to hit her. The resident walked away. Resident #7's responsible party was notified and said the resident had aggressive behaviors when he lived with them. When asked if they would be open to the resident taking medications for the behaviors, they replied they did not want to at that time until they spoke with the PCP. The _____, _____ doctor and PCP were notified. On _____ at 1:23 PM resident #9 reported to staff that resident #7 was in her room. Staff asked resident #7 to leave the room at which time he began yelling. Resident #9 yelled at resident #7 to leave her room at which time resident #7 lunged at #9, grabbed her by the hair, then hit her in the _____. Staff separated them at which time resident #7 swung his fist at the staff. Staff were able to redirect resident #7 to his room without further incident. Resident #7 told staff resident #9 slapped him and said he did not remember hitting her. Resident #7's responsible party was notified.	A 030		

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A 030	Continued From page 30 Local law enforcement was called to the facility based on a request to do so by resident #9's responsible party. When the responding law enforcement went to resident #7's room, he was in bed with his door closed. His responses were minimal, and he did not engage in conversation. On May 13, 2025 at 1:40 PM, staff observed resident #8 in resident #7's bathroom. Resident #7 was observed holding #8's wrist. When staff attempted to assist #8 to use the toilet, resident #7 became aggressive towards them. On May 13, 2025 at 5:23 PM, the administrator documented that on May 13, 2025 resident #7 was aggressive towards staff and visiting providers. The resident forced his way out of the facility when staff attempted to let a resident out of the doors. Resident #7 walked around the property twice then returned inside. On May 13, 2025 at 2:45 PM, resident #7 grabbed a housekeeper by the arm and attempted to choke her. On May 13, 2025 at 10:10 AM, caregiver A said that on May 13, 2025 resident #8 was heard screaming in the marketplace area of the facility. Resident #7 tried to pull #8's pants down. Resident #7 fought with staff when they tried to redirect him. On May 13, 2025 at 3:41 PM, caregiver C said the incident on May 13, 2025 happened sometime during the 7 AM to 3 PM shift. Resident #7 was rubbing on resident #8 while also rubbing his own arm. The caregiver said that on May 13, 2025 sometime during the 7 AM to 3 PM shift resident #8 was using #7's bathroom. Resident #7 was holding #8's wrist. On May 13, 2025 resident #7 pushed his way outside. A caregiver was coming	A 030			

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A 030	Continued From page 31 to work the 3 PM to 11 PM shift and walked with the resident until he came inside. Caregiver C said the staff try to make resident #7 go to his room and they keep an , on resident #8 as much as they can. The caregiver said there were not enough staff to provide adequate supervision. She said the administrator was aware of this but did nothing about it. The caregiver said the administrator told the staff to call 911 if resident #7 acted out. On at 4:30 PM, the wellness coordinator said measures put in place for resident #7 was having a private sitter with him at times and staff made sure they knew where residents #7 and #8 were always. She said that sometimes there were not enough staff to adequately supervise the residents. She said it was hard because staff turnover was high, and residents exhibited sundowning behaviors. On at 12:15 PM, resident #7 was seen sitting at a dining room table. Another male resident was also sitting there. Resident #8 was sitting at a different table located approximately 10 away. Staff were present. On at 12:32 PM, the administrator said staff told her they needed only more medication technicians and no additional care staff. She said the staff also talked about more residents having behaviors. The administrator told the staff the ratio was 1 caregiver to 10 residents and that was the most they would get. Regarding resident behaviors, she told the staff to do medication reviews. She said the residents were acting like memory care residents. She said the facility went from four to five caregivers on both the 7 AM to 3 PM and 3 PM to 11 PM shifts on . She said a notice of discharge was not issued to	A 030			

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A 030	Continued From page 32 resident #7 prior to because that was not up to her. That was decided by the vice president of operations, who instructed her to send all the incident reports to him for review. She said once residents #7 and #8 were put on , , . medications there were no more incidents between them. She said resident #7 currently had a private sitter paid for by the facility who watched the resident at a distance because the responsible party did not want the resident crowded. The sitters were present from approximately 9 AM to 5 PM every day. On at 2:35 PM, activities assistant N said she witnessed incidents between residents #7 and #8 on and . The activities assistant said measures taken to prevent repeat incidents was that she redirected resident #7 when possible and escorted him to activities where he did participate. On at 2:40 PM, activities assistant O said she witnessed the incident between residents #7 and #9 on . The activities assistant said she tried to redirect resident #7 out of the room when he became agitated. Resident #9 then told resident #7 to get out. Resident #7 then hit #9 twice on her with a closed fist. Resident #9 did not suffer an injury. Resident #9's family called law enforcement. The activities assistant said she tried to prevent incidents with resident #7 by redirecting him the best that she can. She said resident #7 participated in some activities but oftentimes got up and walked away. Class II	A 030			
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards	A 093			

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A 093	Continued From page 33 (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.frules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on	A 093			

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A 093	Continued From page 34 the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2	A 093			

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A 093	Continued From page 35 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a 3-day supply of emergency food according to the resident census. Findings: Review of the current census revealed the facility has 67 residents. Review of the facility's emergency supplies, tab 15 in the 2024 CEMP binder stated 3-day emergency food supply. The 72 hour food emergency inventory stated it is the responsibility of the Executive Director to maintain the supply and ensure freshness of all items consisting of: 2 cases of chili, 2 cases of	A 093			

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A 093	Continued From page 36 beef stew, 2 cases of beef ravioli, 2 cases of German potatoes, 1 case of macaroni and cheese, 2 cases of diced carrots, 2 cases of sweet peas, 2 cases of sliced white potatoes, 2 cases of dice pears, 2 cases of diced peaches, 1 case of vanilla pudding, 1 case plum halves, 2 cases of dry cereal, 2 cases of saltine crackers, 2 cases of apple juice, 1 case of cranberry, 1 case of tuna, 2 cases of skippy peanut butter, 2 cases of orange juice, 3 cases of soup, 2 cases of peanut butter crackers, and 30 cans of dry milk. On at 3:07 PM, the chef stated, "I know we don't have enough emergency food." On at 3:20 PM, observation of the facility's emergency food revealed 2 52 oz. cans of sloppy joe, 1 64 oz. can of beef stew, 12 46 oz. cans of soup, 12 46 oz. cans of chicken noodles soup, 12 46 oz. cans of chicken broth, 2 cases of apple juice, 12 64 oz. cans of V 8 juice, 2 cases of evaporated milk, 1 case of 64 oz. Skippy peanut butter, 1 case of Smucker's Jelly, and 1 case 8 oz. Folger coffee. She added, I was trying to use up the current food because it was about to expire. I knew I didn't have enough space to store a new shipment. I was in the process of preparing an order today but didn't submit it. I didn't know you all were coming today. The chef was asked to provide a copy of the order that she stated she had prepared but not submitted. On at 3:23 PM, the chef stated, "oh no, I haven't prepared it yet." The administrator was made aware the facility did not have an adequate supply of emergency food on site.	A 093			

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A 093	Continued From page 37 On at 5:27 PM, the administrator confirmed the findings, stating we can find a new location to store it. On at approximately 6:30 PM, the chef entered the conference and provided a copy of the Sysco Shop on at 4:11 PM with a delivery date of (photographic evidence obtained) Class III	A 093			