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
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 #2025008806 and generator monitoring was conducted at Citrus Garden on . The facility had deficiencies at the time of the survey.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 008	Continued From page 1 request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 008	Continued From page 2	A 008		

shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , , , require such assistance.

59A-36.006
(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,
2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,
3. Any nursing or , , services required by the individual,
4. Any special diet required by the individual,
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,
6. Whether the individual has signs or symptoms of , , , , , , or any other communicable , which are likely to be transmitted to other residents or staff,
7. A statement on the day of the examination that, in the opinion of the examining health care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 008	Continued From page 3 practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 008	Continued From page 4 through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , , to be administered in the case of or , , . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on reviews and interview, the facility failed to ensure a health assessment form (1823) was complete for 1 of 4 sampled residents (13). Findings: Review of resident #13's 1823 health assessment form revealed it was not checked if the resident required 24 - hour nursing or	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 008	Continued From page 5 , , care and address of examiner. There was no documentation to indicate the facility contacted resident #13's health care provider to obtain the missing information. On at 1:08 PM, caregiver A confirmed the findings and unaware the information was missing. (photographic evidence obtained) Class III	A 008		
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 residential setting if all requirements for providing	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 6	A 010		

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 to another without consultation with and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 7 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. (b) A resident requiring care of a pressure	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 8 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 the scope of the facility's license.	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 9 (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 record reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 1 of 4 sampled residents (#13) as required in a assisted living facility (ALF); failed to conduct a consultation for 1 of 1 sampled resident before relocation to another facility (#1). Findings: 1. A record review of resident #1 revealed a facility's admission on . A 1823 health assessment indicated a medical history of , , , , and was not identified as an elopement risk. On at 11:55 AM, caregiver C stated resident #1 did not come on Sunday after he was taken to the hospital. On at 1:06 PM, caregiver A stated resident #1 was taken from the scene to the hospital on . When he was discharged from the hospital the administrator picked him up and he was taken to his new facility Elite Gardens in Rockledge.	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 10 Review of a copy of a resident's contract stated, at the administrator's discretion, of if it is determined upon certification by a licensed physician or an ARNP, that the resident needs services beyond those that the facility is licensed to provided, the resident or next of kin, legal representative, or the agency acting on the resident's behalf shall be notified in writing that the resident must make arrangement for immediate transfer to an appropriate care setting. If the resident does not have a representative acting on his behalf, the facility shall be responsible for making a referral to an appropriate social service agency for placement. On at 1:55 PM, caregiver A stated we did not contact resident #1's POA (power of attorney) or family about the relocation. We've contacted the POA in the past and he refuses to answer our calls. We've informed him that if he no longer wants to be the POA all he has to do is write a letter to the judge. We have not received the letter and we no longer contact him. We did not contact the alternate surrogate and we did not send anything by mail in an attempt to make contact. On 6//19/2025 at 2:00 PM, review of resident #1's designation of heath care surrogate was signed and dated on and the Durable Power of Attorney - Florida signed and dated on . The facility failed to adhere to the regulations moving resident #1 from one facility to another without consultation with agreement from the resident or if applicable, the resident's representative, the resident's family or surrogate. 2. On , review of an incident report dated revealed resident #13 eloped	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 11 from the facility. On at 10:07 AM, resident #13, observed lying in bed, was identified wearing a blue ID . Resident replied, yes when asked if he recalls the incident when he left the building without signing out to look for his wallet and keys. Review of resident #13's 1823 health assessment did not identify the resident as an elopement risk. Caregiver A was asked if a new 1823 was obtained identifying the resident as elopement risk based on the incident. On at 1:08 PM, caregiver A stated we didn't get a new 1823 because resident #13's doctor determined that he was just walking outside and therefore he's not an elopement. Caregiver A continued to say the doctor stated he was not comfortable with indicating the resident as an elopement risk. The facility failed to obtain a new 1823 after a significant change for resident #13. (photographic evidence obtained) Class III	A 010		
A 025 SS=G	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	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 12 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. (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.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 13 (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 interviews, the facility failed to provide adequate supervision to 1 of 1 sampled resident who eloped from the facility by maintaining a general awareness of the resident whereabouts and to ensure safety through proactive measures to minimize the potential for and injuries (#1). Findings: A record review of resident #1 revealed a facility's admission on . A 1823 health assessment indicated a medical history of , , , , , and was not identified as an elopement risk. Review of an incident report submitted to agency for health care administration (AHCA) on stated the outcome of the incident as resident elopement. The resident (#1) was last seen at 4:25 PM when a caregiver (C) brought him to his bedroom as he wanted to rest. The facility received a call from Seminole County at 4:55 PM that they found a man nearby in the neighborhood and gave a description to confirm if he was one of our residents. Identity was verified and we were informed that he will be taken to	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 14 Oviedo Medical Hospital for assessment. At 5:15 PM, Seminole County Sheriff and Paramedics arrived to obtain medical records to bring to the hospital. Then we were informed resident #1 had on the side of someone's house and the neighbor called 911. A facility note on read, resident has a companion at the facility he considers his girlfriend. That resident has since moved out leaving resident #1 searching for her and very about her return. A facility note on read, visited by psych. Resident is more often than not and it isn't just in the afternoon as before, it is now all day long. A facility note on read, due to and , staff called 911 to have resident evaluated. A facility note on read, visited by psych due to increased . A facility note on read, staff has noticed resident is much more . A facility note on read, staff have also noticed resident is after lunch and paces around the house unable to relax. Review of the facility's undated elopement policy and procedure stated, elopement occurs when a resident leaves the property without authorization and staff knowledge or has not returned within one hour of their scheduled return time from a pre-authorized leave. The facility's resident contract addendum under missing resident stated the staff member will	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 15 notify the resident's family or responsible party and resident's physician once it's determined that the resident is missing. On at 11:55 AM, caregiver C stated as far as I know, this has never happened before. I was sitting with resident #1 for about 2 hours working on a puzzle in the day room. I got up to start cooking and went to check on another resident. When I saw resident #1 again, he told me that he wanted to go home. Resident #1 was sitting in the day room when he told me that he wanted to go home. I asked him if he meant his room and he replied yes. So, I took him to his room and then I got a call from the fire department asking if he lived at the facility. I called the administrator. He did not come on Sunday, so we didn't put any interventions in place. On at 12:06 PM, caregiver D stated, caregiver C was working with resident #1 doing a puzzle. I was in a room providing care to another resident. Caregiver C received a call that resident #1 was found down the street. Caregiver C had just put resident #1 in his room. Someone must have left the front door open or ajar because the door has a chime on it and we would have heard it. I can't say for sure, but a lot of families visits on Sunday's. On at 1:06 PM, caregiver A stated I was not working that day when resident #1 left the facility so the staff called the administrator. Resident #1 was really seeking a companion so he would follow us around. He would say he wanted to go home and was referring to his room. We changed his room location and that's when it started. Once we took him to his room he would say, "I'm home". There were no interventions put	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 16 in place because resident #1 was taken from the scene to the hospital on . When he was discharged from the hospital the administrator picked him up and he was taken to his new facility Elite Gardens in Rockledge. Caregiver A was asked for documentation of resident #1's family notification of his elopement and . On at 1:55 PM, caregiver A stated we did not contact resident #1's POA (power of attorney) or family about the elopement. We've contacted the POA in the past and he refuses to answer our calls. We've informed him that if he no longer wants to be the POA all he has to do is write a letter to the judge. We have not received the letter, and we no longer contact him. We did not contact the alternate surrogate, and we did not send anything by mail in an attempt to make contact. She further stated, I've haven't done it. I've have been off all week and today's my first day, when asked about the documentation of the incident. On at 2:06 PM, an attempt was made to contact resident #1's POA and voice message left for a return phone call. On at 2:08 PM, an attempt was made to contact resident #1's alternate surrogate and voice message left for a return phone call. On at 2:30 PM, the department of children and families representative (DCF) arrived at the facility and informed the agency that he visited resident #1 in the hospital. He stated he asked resident #1 some standard questions, like his birth date and his current location. The DCF representative stated resident #1 could not	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 17 answer, and he appeared extremely , . Adding, the resident did not recall what happened or how we got to the hospital. He also stated the hospital informed him that they were calling the facility to get information because resident #1 was not able to answer and unable to make his own decision. The facility failed to provide adequate supervision and general awareness of resident #1 whereabouts, failed to follow their elopement policy by notifying residents' family or responsible party and physician. (photographic evidence obtained) Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 032	Continued From page 18 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 032	Continued From page 19 must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#13). Findings: On , review of an incident report dated revealed resident #13 eloped from the facility. On at 10:07 AM, resident #13, observed lying in bed, was identified wearing a blue ID . The resident replied, yes when asked if he recalls the incident when he left the building without signing out to look for his wallet and keys. The caregivers, C and D were asked if they were made aware of resident #13 eloping from the facility and daily efforts should be made to ensure he has an ID bracelet on at all times. On at 11:55 AM, caregiver C stated I was made aware that resident #13 had eloped from the facility. I was not aware of the bracelet and that I needed to check for it. I was told his elopement wasn't anything. He was just looking for his keys and wallet. On at 12:05 PM, caregiver D stated I know resident #13 wears the blue but I don't	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 032	Continued From page 20 know what it's for or that I'm supposed to be checking for it every day. Caregiver A was asked if daily checks are made to ensure resident #13 has his ID on and to provide the documentation. On at 1:08 PM, caregiver A stated, "No we do not document that we check for his ID. I do recall another surveyor saying we needed to check for it, but I don't recall if it was said we need to document it. The facility failed to provide documented evidence or make a daily effort to ensure resident #13 had his ID on at all times. Class III	A 032		
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 167	Continued From page 21 notice will be given before any rate increase; (e) Any rights, duties, or ˬ of residents, other than those specified in section 429.28, F.S.; (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or , ˏ facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf; (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 167	Continued From page 22 disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, . (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 167	Continued From page 23 (1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and ˛ of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 167	Continued From page 24 which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . . (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or , facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract. (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 167	Continued From page 25 may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's or relocation due to , , hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a residency agreement for 1 of 2 sampled residents (#1). Findings: A record review of resident #1 revealed a facility's admission on . On at 12:42 PM, A request was made to caregiver A to provide a copy of the Residency Agreement for review. On at 12:55 PM, caregiver A stated I don't have access to the contracts. After caregiver A spoke with the administrator via phone. She further stated that the administrator has the keys and they're in her car locked at the airport; adding she will be able to email resident #1's contract on Saturday when she returns.	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964459	A. BUILDING: _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITRUS GARDEN ALF	4805 EAST LAKE DRIVE WINTER SPRINGS, FL 32708

(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 167	Continued From page 26 On at 3:15 PM, caregiver A confirmed the findings, providing no additional documentation Class III	A 167		