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
	AL11910367	A. BUILDING: _____ B. WING _____	06/10/2025

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CRESTHAVEN	5100 CRESTHAVEN BLVD. HAVERHILL, FL 33415

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A 000	Initial Comments An unannounced Licensure Complaint survey, #2025007450, #2024014430, #2024014581, and #2024014806, and a Generator Monitoring survey was commenced on and concluded on at Cresthaven. Deficiencies related to the complaints were identified at the time of the survey.	A 000		
A 010	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 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	A 010		

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A 010	Continued From page 1 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 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	A 010		

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A 010	Continued From page 2 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 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,	A 010		

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A 010	Continued From page 3 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 [redacted] 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. (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.	A 010		

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A 010	Continued From page 4 (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 observation, interview, and record review, the facility failed assess resident care needs to ensure eligibility for continued residency. This was evidenced by the facility's failure to document diagnoses that , care and services for 2 of 2 sampled residents (Resident #29 and #4) and 59 out of 59 sampled residents that have been identified as smokers (S1 -S59). The findings included: a) On at 7:45 AM Resident #29 was observed being pushed in a wheelchair by Resident #36. The resident was slouched to the right in the wheelchair but appeared well-groomed and clean. At this time, the surveyor attempted to interview the residents. Resident #36 began grunting and signaling that both her and Resident #29 cannot speak. Resident #36 then frustratedly rolled Resident #29 to the elevator and took her upstairs. During an interview conducted on with the Front Desk Conceirge at 7:48 AM she stated that both Resident #29 and Resident #36 had and were nonverbal. She further stated that Resident #29 and Resident #36 are always together and Resident #36 is always helping Resident #29. On at 12:23 PM Resident # 29 was observed struggling to eat her lunch meal (soup, sliced hot dog). The resident was slouched over in her wheelchair attempting to spoon piping-hot soup to her . The resident's were	A 010		

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A 010	Continued From page 5	A 010		

unsteady and weak as they continued to shake while she brought the spoon to her . The resident appeared feeble and helpless. At this time, AHCA intervened and requested the resident's food be sent to the kitchen because it was too hot for her consumption, making it unsafe for her to eat given her condition. The kitchen staff returned with the cooled soup and the resident began to eat again. At this time, it was observed that there was no staff assisting the resident with her activities of daily living (ADLs). After a second AHCA intervention, the resident received assistance with her meal, a member of the care staff (Staff) began feeding the resident her lunch meal.

During an interview conducted on with the Executive Director at 12:35 PM, she stated that the resident had a history of 's and was nonverbal. She further stated that the resident was currently on a regular diet, but the staff did assist the resident with her meals by setting up her food for her.

A review of Resident #29's file revealed a Resident Health Assessment form (AHCA form 1823) dated , that documented the following health diagnosis and care needs. The resident's diagnosis was 's. Resident #29 was documented as having physical/sensory limitations related to 's but she has learned effective coping mechanisms to function, communicate and proper self. The resident's status is documented as alert and oriented x3 and aware of situation. The resident is documented as requiring , , , , , , , and care. Special precautions noted as . Additionally, the resident's Activities of Daily Living(ADLs) are noted as as independent with eating and

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A 010	Continued From page 6 self-care(grooming), assistance with ambulation, bathing and [redacted], toileting and transfering. The resident is also noted as requiring set up only and a regular diet. Further review of Resident #29's file revealed a third-party provider note with orders dated [redacted]. The resident was diagnosed with [redacted] and [redacted]/Anarthria per this note. She was referred to [redacted] for treatment and it was documented that there was a plan of care in place. There was no documentation for this plan of care in the file. During an interview conducted on [redacted] with the Executive Director at 4:50 PM, she was informed that Resident #29's Health Assessment form did not reflect the resident's diagnosis of [redacted] and anarthria nor was it reflective of the resident's current care needs. Additionally, she was informed the resident did not have documentation for their plan of care for the diagnosis and the resident was observed struggling with their lunch meal. The Executive Director acknowledged the findings and stated she would have the resident reassessed and modify the resident's diet after reassessment. She further stated she would have staff assist Resident #29 with eating immediately. The Executive Director then stated she would have the resident's 1823 audited to ensure accuracy and eligibility for continued residency. b) Review of Resident #4's file revealed the resident was admitted on [redacted] to the ALF (non-memory care). Review of the Resident's Health Assessment dated [redacted] revealed a medical history of [redacted] and	A 010		

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A 010	Continued From page 7	A 010		

. The resident's or behavioral status documented as alert and oriented x2 (person is aware of their own identity and location). Resident is independent with his Activities of Daily Living (ADLs) and no special precautions noted. The form also noted the resident's needs could be met in an Assisted Living Facility.

Upon admission to the facility the resident was admitted to the non-secured unit. Review of the resident's progress notes revealed the following.
1) (1:59PM)- "Since admission (the resident) has needed with ADLs. Staff encourages him to help-but he just stands there. He is very - of B&B-waling around with BM (movement) in his brief and doesn't mention it or seem to notice. Unable to put his shirt or pants on arms need to be guided by staff. he feeds himself only. He walks around aimlessly in the hallway. Spoke with son at length-agrees to move to memory care unit. "
2) - "He was moved to the memory care at approximately 2:50PM.
3) (1:50PM) - "The resident was standing in the dining room with his walker at 12:40 PM. He took a step , lost his balance and to the ground. he did not hit his . He stated he did not lose . He complained of servere , to his right , when evaluation. MD and emergency contact made aware by phone.

Review of Resident #4's incident's report revealed on at 12:40 PM, Resident transfered to the hospital for injury due to a on . Resident complained of severe , (right) for further evaluation. Resident#4 was transfered to the Rehabilitation and didn't return

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A 010	Continued From page 8 to the facility. Further review of the resident's records revealed the facility failed to reassess the resident for signficant changes and to ensure a new Resident Health Assessment form (AHCA form 1823) was updated to reflect the resident's current care needs. The facility also failed to monitor the resident once transfered to the memory care unit to ensure adequate care and supervision was provided. The facility also failed to document the intervention steps once they identified multiple care concerns regarding Resident #4. c) During an interview conducted with the Executive Director on at 10:44 AM, she provided documentation for the number of smokers at the facility and stated the facility had 59 smoking residents. She further stated she did not have a smoking assessment to assess all 59 residents for their ability to safely use and dispose of their smoking materials. She stated, that assessment of all smokers was apart of her new smoking policy and that the new Management company would be assisting her. Class III	A 010		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the	A 025		

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A 025	Continued From page 9 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. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.	A 025		

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A 025	Continued From page 10 (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate care and services, including supervision to ensure the general health, safety, and physical and emotional well-being of the residents. This was evidenced by the facility's failure to ensure 1 of 3 sampled residents (Resident #1) was monitored after exhibiting signs of violent and aggressive behavior towards residents and staff, leading to an intentionally set fire on . The findings included: Review of local media sources revealed Resident #1 was accussed of arson and setting fire to her room (which was shared with Resident #2) on the morning of . It was noted that Resident #1 set all of Resident#2 personal belongings on fire. Resident #1 had threaten to set the room on fire earlier in the day, in which the roommate decided to sleep in other resident's room out of fear. Review of the facility's investigation report confirmed Resident #1 set fire to her room(shared by Resident #1 and #2). Further review of the investigation report revealed Resident #1 set fire to Resident #2 designated living space in the room. The fire caused damaged to the room and Resident #2's personal belongings.	A 025		

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A 025	Continued From page 11 During an interview conducted on with the Executive Director (ED) and Director of Nursing (DON) at 11:16AM, they stated Resident #1 set her roommate's room (shared by Resident #1 and #2) on fire in the early morning . . . . . . The ED stated that Resident #1 was no longer at the facility and was currently under law enforcement's custody. She further stated the resident would not be returning. Both the DON and the ED stated that Resident #1 had a history of being violent towards staff and other residents. The ED further stated that Resident #1 was served a 45-day notice prior to the incident. Resident #1 set her room on fire the day before she was supposed to be discharged. At this time, a request was made for Resident #1's closed file and the facility's house rules. Review of Resident #1's 45 Discharge notice dated /3025 revealed the resident was issued a termination of residency and must vacate and remove all belongings from the room no later than Friday . . The reasons for the termination noted as: 1) The resident is habitually disruptive, creates unsafe conditions, is physically or verbally to other residents, staff or otherwise endangers the welfare of the resident, other residents or staff. 2) The Resident fails to pay fees and charges when due, or breaches any representation, covenant, agreement, or . . owed by the Resident under this agreement. 3) Facility unable to meet needs due to disruptive,destructive, unsantiary living habits and inappropriate behavior towards others. 4) Violation of house rules outline in your residency agreement rlated to habitual . use.	A 025		

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A 025	Continued From page 12 A review of Resident #1's file revealed the resident was admitted to the facility on . Further review revealed an AHCA form 1823 (Resident Health Assessment form) dated . Resident #1 had a diagnosis of and was documented as not being a threat to herself or others. A review of Resident #1's file revealed progress notes documented by facility staff from to of 2025. The notes contained the following information regarding several incidents of Resident #1's violent behavior: 1. at 8:05 PM written by Staff N (CNA)- " Resident came to the nursing department complaining about confrontational with her roommate (Resident #2) offered her . Resident stated. "I refused she's offered me; she hit me." Writer noted resident had slurring words and smelling . Resident refuses assessed. Resident stated to writer go to hell. 'Resident had obviously been drinking . Resident educated about safety." 2. at 9:26 PM written by Director of Nursing- "She called the police who came in earlier today-she was staggering trying to hold on to her walker. Outside the front of the building yelling "that [. ....] tried to make me drink." The smell of was overwhelming. Both police officers left after talking with her. She put her middle up " [. ...] you too" when both walked to their cars. She went to her apartment and started talking with her roommate. 3. at 6:54 PM written by Director of Nursing and documented as an incident- " Resident entered the dining room at approx. 5pm.	A 025		

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A 025	Continued From page 13 She walked to the table where another resident was eating. She went to grab her cup, stating "that's mine you stole it." Then she hit her on the side of her . Resident appeared , , smelling of . She was slurring her words. She sat down in a chair and started yelling "get me some food". The police arrived. After about 45 mins they issued her a NTA (notice to appear). I asked her for a copy- she refused. The paramedics did come but refused to take her to the ER." 4. Late entry on at 8:37 AM written by Director of Nursing- "Late entry for -police came to the facility and took her to jail for failure to appear. On - she was brought to facility around 7pm. -she came into the library with a pair of scissors, holding by the handle walking towards another resident-the scissors were taken from her. Administrator and I went to her apartment-while the administrator was speaking the resident grabbed her. Police were called, arrived shortly after. Per resident she is moving out next week. She was yelling, "I'm out of this place, I'll stay away from all of you until I'm out of here" 5. at 9:03 AM written by Director of Nursing and documented as an incident- "Approx. 1AM her c/b was used-the aide went to her apartment. Resident was standing outside on her cell phone- "I'm on the phone 911". Smoke was coming out of the front door of her apartment. Per the aide "there was smoke everywhere and I could see all of her roommates things all over the place. The windows were open and stuff had been thrown outside. The sprinklers were on." When I arrived, the fire had been put out. The	A 025		

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A 025	Continued From page 14 apartment damage was up the walls, the ceiling, the bed, furniture. After I left the apartment, the resident was sitting in a chair speaking with the police. Per resident "Don't let any of those [.....] in my room. They will steal my stuff. Cresthaven is going to buy me all new furniture". She was smiling, laughing. "I didn't do it. Refused vital signs and skin check. "Get the [...] away from me." Eventually she was taken by the police." There was no documentation of the facility notifying the resident's provider of her change in behavior, nor was there documentation of an updated AHCA form1823 or internal assessment for Resident #1. Additionally, there was no documentation of increased monitoring or supervision after the change in Resident #1's behavior, after multiple occassions in which the resident exhibited aggressive behavior. During an interview on conducted with the ED at 4:45 PM, she acknowledged that Resident #1's pattern of violent, hostile behavior was a threat to resident rights and safety. She was notified that the failure to closely monitor and assess Resident #1's behavior and interactions with other residents and staff placed the entire resident census at risk of harm. Resident #1 was not reassessed for continued residency nor was her provider notified, despite her growing change in behavior. Furthermore, the resident returned to the facility after being prior to the fire incident. The ED stated her intention was to discharge Resident #1 sooner, as she had given the resident a 45-day notice of eviction. However, the ED stated Resident #1 set the fire the day before her move out. The Executive Director further	A 025		

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A 025	Continued From page 15 stated that she and the DON could have taken more steps to reassess and/or discharge the resident sooner, but they were unsure how to do so without violating resident rights. The ED was notified that allowing Resident #1 to stay was violating the rights of the entire resident census due to her repeated violent actions. She was further notified that resident could have been discharged sooner knowing the impact her behavior had on the community. The Executive Director acknowledged the findings and confirmed she would not be accepting Resident #1 into the facility upon her release from law enforcement custody. She further stated she would be monitoring the residents to ensure any changes of behavior are addressed immediately and are documented accordingly. Class II	A 025		
A 030	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	A 030		

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A 030	Continued From page 16 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. (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	A 030		

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A 030	Continued From page 17 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. 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	A 030		

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A 030	Continued From page 18 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. (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,	A 030		

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A 030	Continued From page 19 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 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. (l) 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	A 030		

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A 030	Continued From page 20	A 030		

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 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

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A 030	Continued From page 21 resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined, the facility failed to implement and follow an effective grievance procedure that demonstrated a system for receipt and resolution of all grievances of residents and/or their representatives. This was evidenced by the facility's failure to maintain documentation of resident grievances, which led to multiple lapses in resident care and supervision, including a fire set in a resident's room on , that . the safety and well-being of the entire resident census (211 out of 211 residents). The findings included: A review of the facility's grievance policy titled, "Grievance Policy and Procedure" (no effective date) revealed the following information: Policy: A resident or responsible party (on behalf of the resident), have the right to express complaint(s) regarding the community or services without , interference, coercion, discrimination, or reprisal. Procedure: 1. The resident and/or responsible party should discuss the concern/complaint/recommendation with the Executive Director or designee. The Executive Director will provide the appropriate Department to resolve the concern/complaint/recommendation. 2. If unable to resolve grievance with step 2, the grievance should be submitted in writing to the Executive Director. The Executive Director should	A 030		

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A 030	Continued From page 22 respond to the resident or responsible party within seven (7) days of receipt of the complaint. 3. If unable to resolve the grievance with step 3, the grievance should be submitted in writing to the corporate support team. The corporate support team should respond to the resident or responsible party within seven (7) days of receipt of the complaint. 4. In the even that no resolution is apparent, the complaint may be filled with the local Ombudsman office. A community representative shall assist the resident or responsible party in forwarding complaints to the appropriate address. 5. The Executive Director will document actions (i.e., contact with family, dates or contact, action plan, etc.) taken response to the grievance. The Executive Director will document these actions on the Seaside Grievance Log. 6. If grievance revolves around a company/community policy, the Executive Director along with a member of the corporate office will review policy and make any necessary changes if applicable. During an interview with the Executive Director on at 11 PM, the facility's grievance policy and procedure was requested. In addition, the facility's documentation of grievances for 2024 and 2025 was requested. At this time, the Executive Director stated she was new and that the prior Administrator/Executive Director failed to document any grievances. She stated she would be taking on the new role and ensuring grievances would be documented. She was informed at this time that all grievances both verbal and written require a written resolution and follow-up. She stated she would ensure that the policy is followed. During an interview conducted on at	A 030		

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A 030	Continued From page 23 9:56 AM with Resident #30, he stated the facility was overcharging him for his rent. Additionally, he stated that he should have received $130 a month for his income and had not received it in a few months. He further stated he complained to the Executive Director and Staff Q (Business Office Manager), and nothing had been done. Resident #30 then stated he even contacted law enforcement for assistance regarding his missing income because Staff Q was rude and unhelpful. During an interview conducted on at 9:01 AM with Resident #16, she stated that it was a , to get medications downstairs. She further stated the lines are always long. She stated that she has expressed her concerns to the Med Techs and CNAs and nothing has been done. During an interview conducted on at 10:01 AM with Resident # 19 he stated that he lived next to Resident #1 and #2's room. He further stated that he witnessed Resident #1 getting violent and aggressive with multiple residents about a month before she set the fire. He further stated that even though she never was violent to him, it made him uncomfortable, and he told the care staff about his concerns. During an interview conducted on at 11:45 AM with Resident #31, he stated that there are fights every now and then and the last fight he saw happened a few months ago. He further stated it's ridiculous and they should not have to deal with that. He stated he has mentioned it to the care staff multiple times, but they never do anything about it. During an interview conducted on at 12:05 PM with Resident #38, he stated that there was a lot cigarette buts, trash and bottles by	A 030		

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A 030	Continued From page 24 rooms D-116 through D-120. He further stated he has complained about it multiple times to housekeeping staff and the Maintenance Director and nothing has changed. During an interview conducted on at 12:45 PM with Resident #37, she stated that verbal arguments and physical violence were constant at the facility but none of it had resulted in injury. She further stated that the care staff was unhelpful and every day at 6:00 PM they hide in the bathrooms and resident rooms. Additionally, Resident #27 stated that both the care and housekeeping staff were not doing their jobs and were stealing personal items from the residents' rooms. She stated that she and many other residents have mentioned these concerns to the previous Executive Director and the Director of Nursing (DON) and nothing had been done. She further stated the new ED was trying, but these problems were there long before her. . During an interview conducted on at 2:26 PM with Resident #2, she stated that she was Resident #1's former roommate and Resident #1 had purposefully her room and personal items on . She further stated that Resident #1 was extremely violent and aggressive towards other residents and staff over the past few months. Additionally, she stated Resident #1 would drink and then come into her room and throw all her items on the floor, throw furniture in her room, and verbally harass her. She further stated that on the day prior to the fire incident, Resident #1 threatened her and told her she was going to ' this place down.' Resident #2 stated she did not feel safe with Resident #1 at the facility, and she voiced her	A 030		

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A 030	Continued From page 25 concerns several times to the care staff, the Director of Nursing (DON), and the Executive Director (ED). During an interview conducted on at 4:45 PM with the Executive Director, she was informed that the facility's grievance binder does not account for several resident complaints regarding physical plant, care and services, medications, financial concerns and resident rights violations. Additionally, she was notified that Resident #1's pattern of violent, hostile behavior was a threat to resident rights and safety. She was further notified that the failure to document and investigate grievances by the facility's policy regarding Resident #1's interactions with other residents and staff placed the entire resident census at risk of harm. The Executive Director acknowledged the findings and confirmed she would not be accepting Resident #1 into the facility upon her release from law enforcement custody. She further stated that she would be enforcing her new grievance policy to ensure compliance with the intake and resolution of grievances. Class III	A 030		
A 123	429.27( ) FS; 59A-36.013(2) FAC Fiscal - Resident Trust Funds 429.27 (3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for	A 123		

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A 123	Continued From page 26 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500. (4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident. (5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies	A 123		

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A 123	Continued From page 27 provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies. 59A-36.013 (2) RESIDENT TRUST FUNDS. Funds or other property received by the facility belonging to or due a resident, including personal funds, must be held as trust funds and expended only for the resident's account. Resident funds or property may be held in one bank account if a separate written accounting for each resident is maintained. A separate bank account is required for facility funds; co-mingling resident funds with facility funds is prohibited. Written accounting procedures for resident trust funds must include income and expense records of the trust fund, including the source and disposition of the funds. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to maintain an accurate record that itemized income and expense records of resident's funds for all residents in which they serve a payee representative, for 55 out of 55 Residents(Resident #30). This failure resulted in the resident's inability to meet personal needs, causing delays and withholding funds owed to resident. The findings include: During an interview on at 9:56 AM	A 123		

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A 123	Continued From page 28	A 123		

with Resident #30, he stated the facility was overcharging him and withholding his funds. He further stated he was entitled to receive $130 per month but had not received the funds for several months. As a result, he had been unable to purchase personal items. Additionally, he stated that he spoke with Staff Q (Business Office Manager) multiple times about the inconsistencies with his funds and she was unhelpful. Consequently, Resident #30 stated that he contacted the law enforcement due to concerns about the facility's financial mismanagement.

During an interview on at 3:00 PM with Staff Q, she was asked to provide Resident #30's expenditures and income. She stated they only documented the rent. She also stated they do not have a resident fund statement they only maintain a ledger.

A record review of Resident #30's file revealed Resident #30 signed a contract with the facility on and the total fee for the contract was $2901.00. Further review revealed two different rental rates, $651 and $850. It was documented that the resident received $681.00 per month from Social Security. Further review revealed Resident #30 was entitled to 130 as personal money each month (remaining funds after rent expenditure).

The facility's Resident Trust Record showed the resident received only $30 on with no consistent monthly disbursements. The residential fund documentation Staff Q provided for - was inconsistent, and there was no clear explanation of the amounts owed or paid by the resident or Medicaid.

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A 123	Continued From page 29 During an interview on at 3:10 PM with Staff Q, she stated she could not explain how Resident #30's monthly rent was or what amounts were owed or paid. b) During an interview with the Business Office Manager (Staff Q) at 12 PM, she was requested to provide a list of all residents in which the facility serves a payee respresentative. She stated the facility has 55 residents in which they serve as payee representative (for social security income). She stated, the facility was recently audited by the Social SecurityOffice, in which they were informed that they had to maintain a separate banking account for the payee representative funds and documentation of the income. She stated, the facility had only created rental ledgers and had not documented the income funds and all expenditures on a monthly basis reflecting any current balances (credits for the residents). It was also revealed that the facility had not provided the residents with quarterly statements or information regarding their resident trust balances. She further stated, she maintained a weekly cash log in which residents are allowed to withdraw money, however, she was not able to provide documentation of the balances in each resident's account to allow full access of these funds to each specific resident. The facility was also unable to show accurate running balances of these withdraws for the residents. During an interview on at 2:25 PM with the Administrator, she acknowledged that the current accounting documentation and records were inaccurate. She stated that changes to the financial process were underway. The Administrator was unable to provide a clear and consistent record of residential funds for Resident	A 123		

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A	Continued From page 30 #30 for the past four months. During an interview with the Administrator on at 4:15 PM, she acknowledged the findings. The Administrator agreed that the facility owed Resident #4 a monthly payment of $130 retroactive from , of 2025. Class III	A 123		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested.	A 152		

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A 152	Continued From page 31 (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a safe living environment free of hazards. This was evidenced by the facility's failure to ensure the smoking residents comply with the facility's smoking policy and procedure by safely disposing smoking materials. The findings included: A review of the facility's smoking policy titled, " Smoking/ Policy" (no effective date) revealed the following information: Policy: Smoking is only allowed in designated areas. The Community wishes to accommodate both smokers and non-smokers comfortability. The community only has one (1) designated smoking area. - Cigarette buds are to be disposed of in the ashtrays provided in said designated area. - Smoking is not allowed anywhere inside the community; this includes anywhere inside a residents' rooms, resident's bathroom. - No smoking in the courtyard area, unless specifically designated.	A 152		

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A 152	Continued From page 32 During an interview conducted on with the Executive Director at 9:47 AM, she stated the facility's smoking policy was being revised. She further stated she was new to the role of Executive Director and she intended to make changes to the community to ensure compliance with the smoking policy. Throughout the tour of the designated smoking area and non-smoking areas and the following observations were made: A. Room B-115(outside of the room, front entrance) - the resident had a large size ziplock bag filled with cigarette buts under his patio chair. The resident also had a small can filled with cigarette buts and ashes under the same patio chair (Photographic evidence obtained). Resident's room also had a strong cigarette odor. The patio furniture was composed of flamable material. B. The courtyard- On both days (and), observations revealed over a dozen residents were smoking in the courtyard. All smoking residents were observed ashing their cigarettes directly onto the concrete, into the bushes, and into the grass. There was a large volume of cigarette buts observed scattered heavily throughout the grass around the perimeter of the courtyard (Photographic evidence obtained). C. Hallways and common areas- Throughout the tour of the resident outdoor hallways and common areas (activity room, lounge area, and main entrance) there was a strong cigarette odor. D. Elevator- The left elevator for the D-wing was out of service and had yellow caution tape crossed over the open elevator door. F. Carpet noted in the main building extremely	A 152		

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A 152	Continued From page 33 dirty and heavily soiled, large accumulation of dirt and unknown particles and spots throughout the second floor. During an interview with the Maintenance Director on [redacted] at 9:23 AM, he stated that the elevator is currently under maintenance and it is in the process of being repaired. He further stated the yellow caution tape crossed over the open elevator door. The Mainteance Director was unable to provide a date the elevator would be repaired and returned to service. During an interview conducted with the Executive Director on [redacted] at 10:44 AM, she provided documentation for the number of smokers at the facility and stated the facility had 59 smoking residents. She further stated she did not have a smoking assessment to assess all 59 residents for their ability to safely use and dispose of their smoking materials. During an interview conducted with the Executive Director on [redacted] at 12:35PM she was informed that the residents were not following the facility's smoking policy. Additionally, she was notified that the residents were ashing in the grass and bushes and there were cigarettes buts surrounding the perimeter of the courtyard. She stated that she would be cleaning up the cigarette buts and that she already began moving the designated smoking area further away from the courtyard to prevent residents from ashing in the grass. She further stated she planned on having her consultant nurse assess all 59 residents to determine if they could properly maintain their smoking materials. The Executive Director acknowledged the findings and stated the new policy and resident assessments would be used	A 152		

Agency for Health Care Administration

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A 152	Continued From page 34 to maintain compliance. Class III	A 152		