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
	AL11965458	A. BUILDING: _____ B. WING _____	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN COVE ALF	918 EGAN DRIVE ORLANDO, FL 32822

(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
ZZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ˬ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ˬ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ˬ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	ZZ815		

AHCA Form 3020-0001

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

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ZZ815	Continued From page 1 qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently	ZZ815		

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ZZ815	Continued From page 2 obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible	ZZ815		

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ZZ815	Continued From page 3 to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria	ZZ815		

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ZZ815	Continued From page 4 relating to retaining ⌣ , pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an	ZZ815		

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ZZ815	Continued From page 5 exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter,	ZZ815		

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ZZ815	Continued From page 6 terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, review of the background screening website, and interview, the facility failed to ensure 1 of 1 person (A) who was alone with the residents and who had access to resident's personal property and living areas had a background screening. Findings: On at 8:40 AM, female A was the only nonresident in the facility. She said the administrator had to run out but would be right . On at 8:54 AM, the administrator arrived at the facility. She said there were currently five residents. All five were seen. Female A left the facility. On at 10:52 AM, the administrator said only she and the co-owner were employees. She said female A was a family member who lived upstairs. On at 11:10 AM, review of the background screening website revealed female A was not located using her name. The	ZZ815		

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ZZ815	Continued From page 7 administrator said she called female A to get more identifying information to be used to look her up, but she could not reach her. She said female A lived upstairs with her spouse and had to enter and exit through the licensed portion of the facility and through the resident's living area. Unclassified	ZZ815		
A 000	Initial Comments A complaint investigation (2025011579) and generator monitoring were conducted at Golden Cove ALF on . The facility had deficiencies at the time of the survey.	A 000		
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 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	A 025		

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A 025	Continued From page 8 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. (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, record review, and interview, the facility failed to provide adequate supervision when 1 of 5 sampled residents (1) eloped from the facility.	A 025		

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A 025	Continued From page 9 Findings: A emergency department note indicated the resident's previous facility would not take her because of her aggression. Review of resident #1's record revealed a facility admission date of . The residents' medical history included . A health assessment (1823) indicated she had short-term memory and related to and had recent increase in agitation and aggression. Special precautions were and risk. A admission note indicated the family reported the resident had some restlessness and had multiple prior visits to a hospital for increased restlessness. On resident #1 slept most of the night. She continued to be and restless in the evening that was more noticeable. She was redirected and encouraged to do activities with no effect. On her and restlessness continued. On she was more agitated and restless in the evening. She was redirected with some effect. On her daily and sundowning behavior was not improving. On her level did not improve with the increase in medication. She became combative. She refused her medications. She packed her belongings. Her gait was unsteady.	A 025		

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A 025	Continued From page 10 On the , helped with her restlessness and agitation however, she began tearing up everything she could find, including her pull-up which she then put in the toilet. On she continued to destroy everything in her path. The previous night she was up going through a cabinet in the TV room and opening things. On a , , , consult was ordered due to severe with agitation. On the health care provider was informed the restlessness improved, but the resident was still not sleeping all night. On her daytime restlessness improved some in the morning. She paced less because she did not sleep much. She paced around the house during the night and had sundowning behavior. On she took short naps because she did not sleep much at night. She was and disoriented throughout the day with increased restlessness in the evening. She had sundowning behavior. She finished dinner around 5:30 PM. The administrator began providing care to the other residents. Resident #1 found an opportunity to open the front door. She walked in the neighborhood one where a neighbor called emergency medical services because the resident was and knew only her first name. She was transported to a hospital. The hospital reported she arrived at 6:15 PM. The administrator noticed she was missing from the facility at around 6:30 PM. The administrator searched for the resident inside and outside the	A 025		

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A 025	Continued From page 11	A 025		

facility. The administrator phoned the other staff who arrived within five minutes to watch the remaining residents while the administrator drove her car to continue the search. At 6:52 PM the administrator phoned a neighbor who said the resident was seen on another neighbor's ring camera. At 6:55 PM the administrator phoned 911 to ask about the incident and was told to call the hospital for further information. The administrator then drove to the hospital. The resident gave the hospital three different last names, none of which were her last name. At 10 PM the resident was discharged from the hospital and returned to the facility.

On every hour during the first part of the previous night the resident looked out the window and yelled with . She slept a little later in the night.

On she was still not sleeping most of the night. . Restless. The administrator gave a verbal discharge notice to the family.

On a 45-day written discharge notice was given.

On she was seen in a doctor's office. The doctor documented worsening with agitation and aggression. The visit was for a follow-up after she escaped from the facility.

On she was , disoriented with evening restlessness. Sundowning. Looking for family members. Going in and out of the fence in yard. Family actively searching for another facility.

On at 8:55 AM, resident #1 was seen sitting in a chair and coloring. She was alert and

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A 025	Continued From page 12 pleasantly . On at 10:38 AM, the administrator said the last facility discharged resident #1 for disturbing the other residents and for being verbally . The administrator said when she went to see the resident at the previous facility the resident was angry at her family member for bringing the administrator there. On at 10:40 AM, the administrator said she was the only person working when the resident eloped on . The administrator said the resident was up and down most nights. At around 2 PM or 3 PM she started walking around. She followed the staff. On she finished dinner at 5:30 PM. The administrator last saw the resident at around 5:45 PM when the resident went into her room. The administrator went into another resident's room and closed the door to provide care. At around 6 PM the administrator exited that resident's room. She did not see resident #1. She noticed the front door was unlocked. When the co-owner arrived, the administrator drove in her car to look for the resident. A neighbor said a ring camera showed a elderly woman on a street located approximately one-half mile from the facility. A different neighbor called 911 when the resident sat on their porch and appeared . Two hours before the elopement, the administrator noticed the internet was out and didn't think much of it. She realized the next morning it was unplugged and believed it was done by resident #1. The internet outage was the reason the facility's own ring camera did not alert. The administrator did not previously discharge the resident because she was trying to get the resident in to see a psychiatrist and medication changes were done.	A 025		

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A 025	Continued From page 13 On at 11:35 AM, the administrator said the front door alarm was turned off when the resident eloped because the administrator turned it off when she went to get the mail and forgot to turn it on. On at 12:40 PM, the co-owner said the resident at night. He said he slept himself for a while when he worked. Before going to sleep he made sure the resident was asleep. He gets up every 30 minutes to an hour and finds the resident . He stays with her until she asleep again. He said the door alarms were turned on at night. 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		

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	AL11965458	A. BUILDING: _____ B. WING _____	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN COVE ALF	918 EGAN DRIVE ORLANDO, FL 32822

(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 14 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		

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A 032	Continued From page 15 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 review, and interview, the facility failed to ensure 1 of 5 sampled residents (#1) with a history of elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number, failed to have a photo ID of that same resident on file that was accessible to all facility staff and law enforcement as necessary, and failed to ensure 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 ID on their person. Findings: Review of resident #1's record revealed a facility admission date of . The residents' medical history included . A 1823 indicated she had short-term memory and related to and had recent increase in agitation and aggression. Special precautions were , , and risk. On the resident eloped from the facility. The record did not have a current photo ID of the resident. On at 8:55 AM, resident #1 was seen sitting in a chair and coloring. She was alert and pleasantly . On at 10:52 AM, the administrator said	A 032		

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A 032	Continued From page 16 she only had photos of the resident participating in activities on her mobile phone. On at 11:16 AM, the administrator said the resident did not have ID on her person because she would not keep it on. There was no documentation to indicate the facility made, at a minimum, a daily effort to put ID on the resident. The facility's undated resident elopement policy did not indicate the facility would make a daily effort to ensure the ID was in place. On at 11:17 AM, the administrator confirmed the findings in the policy. Class III	A 032		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency	A 083		

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A 083	Continued From page 17 medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses was always in the facility. Findings: On at 8:40 AM, female A was the only nonresident in the facility. She said the administrator had to run out but would be right . On at 8:54 AM, the administrator arrived at the facility. She said there were currently five residents. All five were seen. Female A left the facility. On at 10:52 AM, the administrator said only she and the co-owner were employees. She said female A was a family member who lived upstairs. On at 11:25 AM, when asked if female A had training in first aid and , the administrator replied, "I don't know, I don't think so." The administrator said female A was alone in the facility this morning because the administrator had to run out to buy something. Class III	A 083		