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
	AL11969553	A. BUILDING: _____ B. WING _____	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT TAMAYA	3270 TAMAYA BLVD JACKSONVILLE, FL 32246

(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 for complaint numbers 2025008072 and 2025007793, along with a generator monitoring, was conducted at Grand Living at Tamaya from to . Deficiencies were identified in the complaint survey. Class I deficiencies were found at Tags 0030 and 0077. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to ensure that one of five residents sampled, Resident #4, had the right to a safe living environment. The facility failed to ensure that one of five residents sampled, Resident #1, had access to adequate and appropriate healthcare. The facility failed to ensure consistent oversight was provided by facility Administration to ensure resident care and services were provided according to their own policies, and state requirements. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 2:15pm. The census at the start of the survey was 106.	A 000		

AHCA Form 3020-0001

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

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A 000	Continued From page 1 The following is a description of the deficiencies found at the time of the visit.	A 000		
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 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	A 030		

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

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A 030	Continued From page 3 (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility.	A 030		

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A 030	Continued From page 4 (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual	A 030		

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A 030	Continued From page 5 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 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	A 030		

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A 030	Continued From page 6 Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to preserve the right to adequate and appropriate healthcare for Resident #1 who received life-saving measures which contradicted his advanced directives which included a ( ). Twenty-one (21) other residents had on file at the time of the survey. Additionally, the facility failed to maintain a safe living environment for Resident #4 who alleged resident-to-resident . Management failed to timely investigate the validity of the allegation. At the time of the survey eleven (11) other women resided on the floor with the alleged	A 030		

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A 030	Continued From page 7 , as well as the resident who made the allegation. The findings include: 1. Review of Resident #1's sheet showed he moved into the facility on and resided in unit 309 (on the third floor of the facility). The sheet included demographic data and a line of the form indicated Resident #1's code status was ( ). (Photographic evidence obtained) An 1823 Health Assessment dated revealed Resident #1 was alert and oriented. His diagnoses included: , , , , Atherosclerotic , prostatic hyperplasia, sleep . Resident #1 was independent with eating and required supervision with ambulation, bathing, , self-care (grooming), toileting and transferring. (Photographic evidence obtained) The progress note for Resident #1 revealed that on at 8:02 am, Resident #1 pressed his pendant for assistance. Staff were "looking for him and could not find him" but a dietary worker located him on the first floor of the facility and Emergency Medical Services ( ) was contacted. Hospital records revealed Resident #1 was provided life-saving measures by despite having an executed . (Photographic evidence obtained) During an interview on at 2:40 pm with Employee L, a Licensed Practical Nurse (LPN) she confirmed working the morning of when Resident #1 was found unresponsive. She	A 030		

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A 030	Continued From page 8 stated there was a delay in locating Resident #1 as his pendant was showing him in another location of the facility. Instead of being located where the pendant indicated, Resident #1 was actually was found unresponsive in a first-floor men's restroom. Employee L explained that staff were trying to locate Resident #1 for an undisclosed amount of time on the upper floors near his bedroom, but by the time she located him on the first floor, were already in the facility and "working on" him. She confirmed that Employee Q, Weekend Receptionist, was working at front desk on . She stated she observed "working on" Resident #1 as he exited the facility to go to the hospital, indicating Resident #1 was receiving , as he was transported out of the facility. At 3:41 pm on , Employee H, Caregiver, also stated she experienced issues with the pendant system. She explained former management in the building requested screenshots of the issues and emailed them to her, because she was trying to get the system fixed. She explained you have to look around to where the resident would normally go, the location you receive is just an estimate and not exact. She gave an example of a resident who pinged as being in her room on an upper floor, but she was actually in the dining room on the first floor. Employee H explained it can cause a delay in care. Employee I was interviewed on at 4:57 pm and stated she had issues with the pendant showing the wrong location "every day" and the locater only gives an approximate location. She said there is a delay on when they push the button and when they get the alert, and it can	A 030		

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A 030	Continued From page 9 take 30-45 seconds to alert them of the pendant call. On at 11:25 am, Employee N, Receptionist, stated in an interview that when arrived, her responsibility was to give them a copy of the sheet and a copy of the if one was executed. She has access to the but could also pull them up online where they were stored. Employee O, dishwasher, was interviewed at 12:40pm on . He confirmed he found Resident #1 and asked the front desk receptionist to call a nurse. He returned a second time and had to make a second request for a nurse to be called. During an interview on at 12:54 pm with Employee P, who was the Lead Server working in the dining room on the first floor of the facility on . She was alerted by Employee O that when he went to the restroom he found Resident #1. When she arrived she found Resident #1 unresponsive, and advised Employee O to alert Employee Q, Weekend Receptionist, to call for a nurse. She could not recall how long she waited for direct care staff to come down to the first floor. She stated that Employee Q informed her that she was not able to reach the nurse so at that time she advised Employee Q to call 911. She stated she kept looking at his for signs of breathing but it wasn't moving, and he began turning blue and purple. arrived within minutes. And she observed the team check Resident #1 for a , ; when she heard staff respond that Resident #1 did not have a , they began , . Resident #1 was then lifted onto a stretcher with a machine performing	A 030		

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A 030	Continued From page 10 , . She said she did not observe direct care staff arrive to Resident #1's location until the team was in the building. During an interview on at 10:55 am with Employee Q, she acknowledged the incident on involving Resident #1. When she was told Resident #1 was found unresponsive in the first-floor men's room, she made 2 calls to the nursing staff for assistance. She eventually she called 911 after none of the direct care staff responded. She observed the nursing staff arrive about the same time arrived. When asked to explain her role when was coming to the facility. She explained she provided only a copy of the residents sheet, adding she did not make a copy of the yellow form. She confirmed the yellow forms and sheets are located in a binder at the reception desk. She stated that she gave the worker a copy of Resident #1's sheet upon their arrival, they left to go locate him, and the status was written on that paper. She stated remained with the resident for approximately minutes. She confirmed that she did not provide the team with the yellow form. She stated the nurse provided the team with the yellow form as they were rolling Resident #1 out of the facility. Review of the facility's policy showed the staff were responsible for presenting with an executed upon their arrival to the facility. (Photographic evidence obtained) 2. Review of Resident #4's records showed she moved into the facility on and she currently lived on the third floor. An 1823 Health Assessment dated showed she was	A 030		

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A 030	Continued From page 11 alert and oriented times two. Her diagnoses included: 's ; essential tremor; ; , / ; , ; , ; idiopathic , , , , . Resident #4 was independent with eating, self-care (grooming), toileting and transferring and required assistance with ambulation, bathing, and . Photographic evidence obtained. An interview was conducted on at 2:03 pm with two representatives of Resident #4. During the interview they called a third representative who described an incident between Resident #4 and a male independent living (IL) resident who lived on the same floor. In , the representative was visiting and observed the male IL resident following them (she and Resident #4) to the car and staring at them. Resident #4 became visibly upset and stated she thought he was gone. At this point Resident #4 confided in the representative that at sometime between and , of 2025, the male IL resident "lured" Resident #4 into his apartment to look at some books, but when she entered, he closed the door and locked it, and the male IL resident tried to kiss her and put his down her pants. Resident #4 told her representatives she fought him off and left but did not tell anyone. When the representative heard this, she made the Administrator aware. The Administrator was interviewed on at 10:26 am by phone. She stated she has not received any complaints about or neglect. She described one call to the Department of Children and Families (DCF) which was unrelated to Resident #4 or the male IL resident. She said she had had no complaints since , . During an interview on at 1:43 pm with	A 030		

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A 030	Continued From page 12 Employee J, she acknowledged that she was made aware of the incident involving Resident #4, which occurred between and , . She confirmed that reports of and/or neglect are to be reported to the state. Employee J acknowledged one of Resident #4's representatives wanted to report the incident to the Administrator, but she was not in the facility. Employee J contacted the Administrator herself, and the response she got was that she would reach out to Resident #4's representative. She stated that she did not submit a written statement nor did she interview either resident. She again stated she contacted the Administrator and was advised that she would reach out to the Resident #4's representative. A second interview was conducted with Resident #4's representative on at 11:53 am. She said Resident #4 has described the incident the same way many times and the only thing that changed is what Resident #4 did in response; sometimes she says she kicked him, sometimes she said she slapped him. She explained she was told by staff members that Resident #4 shouldn't be allowed to socialize with the male IL resident. (This was to clarify a statement made in the earlier interview when the representatives stated they were warned to stay away from him because of he had a history of saying inappropriate comments to women.) She initially reported her concern to Employee R, Evening Receptionist, who urged her to speak with management. Resident #4's representative described the Administrator as "nonchalant" and that she didn't want to "cause any waves" because he was moving out anyway. Employee L was interviewed again on at 11:55 am and she stated there had been	A 030		

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A 030	Continued From page 13 "complaints" about the male IL resident. He asked a lot of women out and has "harassed" people in the parking lot by handing them fake parking tickets. The Resident Occupancy Agreement updated was reviewed. Page 22 Exhibit K included the , Neglect, , (the reporting of) policy: Every Resident has the right to live in a safe place free from , neglect and , . Therefore, this community establishes and fosters an environment of respect for residents so that no one will become a victim. The contract went on to also include information about reporting to DCF:3. Florida Statute mandates that all assisted living personnel be responsible for reporting any suspicion of , neglect, or , . 4. Should a Resident be in immediate danger staff are instructed to call 911, otherwise, reporting can be done by telephone. Telephone numbers for reporting can be found in common area of the community. Depending on the severity of the report the central hotline will assign an investigator immediately or within 24 hours. Once a call has been made the Administrator or designee should be made aware of the situation. 6. The Executive Director or designee will a) investigate the grievance immediately, b) if staff member involvement, the alleged staff member will be removed from duty pending the outcome of the investigation. (c) as part of the investigation all other residents under the care of alleged staff member will be interviewed. (Photographic evidence obtained) On at 2:05 pm the Administrator and	A 030		

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A 030	Continued From page 14	A 030		

the Regional Director of Health and Wellness (RDHW) were contacted by phone about concerns identified with Resident #1 and Resident #4. Both of the staff members voiced their disagreement that anything could have been done differently with Resident #1. The RDHW stated that she was not familiar with the requirement to report incidents like this. She was directed to the facility's contract, but said she did not know the details, so the contract was read to her from the facility's Reporting Policy section of the Resident Occupancy Agreement.

The Administrator stated that she was "vaguely familiar" with Resident #1. She stated she knew what had been reported by the team. She stated that she was informed by the nurse that Resident #1 had pushed his pendant and it showed he was on the 2nd floor. She stated the nurse informed her that the resident was a . She could not provide any additional information on the matter.

She was asked if she had had any interaction with Resident #4, but she responded that she didn't recognize the name. She confirmed she had not reported the incident with Resident #4 and the male IL resident because she did not think it was a report of . She stated she felt it was just a "casual conversation." She again stated that she could not recall if another staff member, past or present, had informed her of the incident. While the Administrator initially denied being advised of any physical contact between Resident #4 and the male IL resident, she confirmed knowledge of the concern with the male IL resident chasing Resident #4 and her representative outside of the facility, and knowledge that Resident #4 was worried the male IL resident would follow her around the facility. She confirmed that she told Resident #4's

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A 030	Continued From page 15 representatives that the male IL resident was leaving the facility and that he was on a waiting list for another community. She stated she became aware of the situation around the first week in , but she had spoken to "a lot of people" when she started and does not remember them all. She denied receiving any reports from staff members. The Administrator acknowledged there was no formal investigation into it and had not followed up with Resident #4 or her representatives. Employee R was interviewed on at 3:20 pm. She confirmed when came in she needed to give them a resident's when they arrived. She also stated she had made complaints to her immediate supervisor about the behaviors of the male IL resident involved in the incident with Resident #4 and acknowledged she was approached by the representatives for Resident #4 and they relayed their concerns he forced himself on her. She has not received any guidance or education from anyone since the incident was reported to her. Class I	A 030		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120	A 077		

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A 077	Continued From page 16 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after	A 077		

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A 077	Continued From page 17 becoming employed as a facility administrator. Administrators who attended core training prior to , . . , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.	A 077		

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A 077	Continued From page 18 (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide day-to-day oversight by the Administrator in a manner that ensured facility policies were followed, and resident rights were maintained. The facility failed to ensure a core trained/tested designee was in place in the Administrator's absence. Failing to ensure Administrative coverage to investigate concerns and supervise operations has the potential to affect all residents. The findings include:	A 077		

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A 077	Continued From page 19 1. Upon arrival to the facility on at 9:30 am, an interview was conducted with, the Business Office Manager (BOM). She referred to the Administrator of Record with the Agency as the "interim Administrator" but clarified that she was in another city. She contacted the Administrator by phone. The Administrator confirmed that she was the "interim Administrator" of the facility, and explained she also served as the Administrator in the sister facility which was located 4 hours away. A Notification of Change in Administrator form sent to the Agency identified the Administrator of Record as the facility's new Administrator effective . The form indicates on page 2 that this Administrator was also responsible for a sister facility located 148 miles from this facility. (Photographic evidence obtained) During an interview on at 12:14 pm with the Director of Health and Wellness (DHW) she stated her start date was . She stated there was no manager in writing at the facility when the Administrator was away, but she knew that it was required and that she had reached out to the Administrator regarding the matter. She confirmed that she was not core trained. She added: "There's a lot that we need that's not in place." During an interview on at 12:31 pm with the BOM, she was asked to provide a list of grievances. She stated that the previous Administrator kept a log of grievances but that the current Administrator verbally advised her that there had not been any grievances filed in the facility in the last 90 days. The BOM stated there was no log to confirm this. She stated she had the grievance log which was maintained by the	A 077		

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A 077	Continued From page 20 previous Administrator, but the current Administrator did not maintain a record of any grievances. During an interview on at 3:39 pm with the DHW, she also stated the Administrator advised her "that any family complaints the Administrator received, she handled them verbally. She doesn't write anything down. She handles them in-house. She did a family resident council meeting." During the interview with the DHW she provided a grievance binder that documented grievances thru . She also provided 2 typed statements regarding the managerial oversight in the facility during the Administrator's absence. (Photographic evidence obtained) Statement #1, dated , stated the Regional Director of Health and Wellness (RDHW), "will assist in covering [the facility] in her absence." Statement #2, dated , also stated the RDHW would assist at the facility in the absence of the Administrator, but that the personnel in the building would be the DHW (responsible for clinical) and the BOM (responsible for operations) during the Administrator's absence. The form indicated the BOM and DHW were scheduled to attend core training in , . Both statements contained the Administrator's contact information and were unsigned. Review of the facility's Background Clearinghouse Management System showed the RHWD was not on the facility's roster. (Photographic evidence obtained) During an interview on at 4:39 pm with the DHW, she was asked about the statements	A 077		

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provided regarding the managerial coverage in the facility. She stated that she was not "involved in that." She stated the information was printed out and given to the BOM, who then gave it to her. She stated that she had only observed the RDHW in the facility for one week since she started at the end of , and was otherwise only available by phone if needed. She stated the RDHW had advised the Administrator that there needed to be a statement delegating a manager on duty, and that the DHW needed core training.

A phone interview was conducted with the Administrator on at 10:26 am. She apologized for her absence during the survey but that she was the Administrator of a different assisted living facility which was located 4 hours away She stated she would be the "permanent Administrator" at this facility as of . She stated she would be to this facility on and that she would be in the facility days a week. She confirmed the BOM and DHW were not core trained. She stated "things are still being worked out and there's a lot going on."

She was asked about grievances. She stated there were no complaints in , . She did not document grievances; she held monthly resident chats. She stated she usually handled things immediately so felt no need to document them because they were resolved. She stated that in , she reported to the facility to introduce herself as the "interim Administrator." She stated that she was not aware that she had to document grievances. She stated that she had not documented grievances her entire career and did not consider anything she could handle immediately as a grievance. She confirmed there were no reports or investigations into anything

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A 077	Continued From page 22 related to Resident #1 on . The facility's Resident Occupancy Agreement updated was reviewed. Page 22, Exhibit J, Grievance Policy listed the following details: Residents, family members, responsible parties, or interested parties will be allowed to express their concerns freely, without any fear of retaliation. The Executive Director will address concerns courteously and in a timely fashion giving Residents, families, responsible parties, and interested parties a satisfactory resolution to their concerns... (4.) Within 24 hours, the Executive Director or designee will document a record of the grievance as discussed with the Resident, family member, responsible party, or interested party. This is to include the grievance, name of involved parties, disposition and date. (5.) The Executive Director or designee will a) investigate the grievance within 72 hours, b) report our findings by the end of the next business day to the Resident, family member, responsible party, or interested party and c) document the response. (7.) Final resolution of the grievance will be documented by the Executive Director. (8.) Any completed grievance report will be kept on file and made available to survey process as requested. Photographic evidence obtained. 2. Record review revealed on at 8:02 am, Resident #1 pressed his pendant for assistance. Staff were unable to locate him, but when he was located by dietary staff on the first floor, they alerted Emergency Medical Services ( ). Hospital records revealed Resident #1 was provided life-saving measures by despite having an executed	A 077		

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A 077	Continued From page 23 ( ). Photographic evidence obtained. During an interview on at 2:40 pm with Employee L, a Licensed Practical Nurse (LPN) she confirmed working the morning of when Resident #1 was found unresponsive. She stated there was a delay in locating Resident #1 as his pendant was showing him in another location of the facility. Instead of being located where the pendant indicated, Resident #1 was actually was found unresponsive in a first-floor men's restroom. Employee L stated that staff was trying to locate Resident #1 for him for an undisclosed amount of time, but by the time she located him, were already in the facility and "working on" him. She could not say who verified Resident #1's code status. She confirmed that Employee Q, Weekend Receptionist, was working at front desk on . She stated she observed "working on" Resident #1 as he exited the facility, indicating Resident #1 was receiving , as he was transported out of the facility. On at 1:43 pm, Employee J, Sales Counselor, stated she received a text in a text chain on that Resident #1 from a in the bathroom at the facility. Review of the texts showed a conversation including the DHW, Assistant Director of Health and Wellness (ADHW), BOM, and Memory Care Director. The DHW texted that he pushed the pendant in the bathroom by the dining room and staff had to locate him because the location said he was near . 911 was called once he was located. (Photographic evidence obtained) During an interview on at 12:54 pm with Employee P, Lead Server who worked in the dining room on , she confirmed	A 077		

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A 077	Continued From page 24 observing Resident #1 unresponsive in a men's room on the first floor . She could not recall how long she waited for direct care staff to come down to the first floor. She stated that Employee Q informed her that she was not able to reach the nurse so at that time she advised Employee Q to call 911. arrived within minutes. She observed report that they could not find a , , and Resident #1 received , . Resident #1 was then lifted onto a stretcher with a machine performing , . During an interview on at 10:55 am with Employee Q, she acknowledged the incident on involving Resident #1. She stated that she was told a member of the dining staff found Resident #1 unresponsive in the first-floor men's room, and she made unsuccessful attempts to contact the nursing staff for assistance. She then called 911 after none of the direct care staff responded to her calls. When asked to explain the process for coming to the facility, she explained she provided only a copy of the residents sheet adding she did not need to make a copy of the for because that was on the sheet she provided them. She stated remained with Resident #1 for approximately minutes. She confirmed that she did not provide the team with the yellow form. She stated the nurse provided the team with the original yellow form as they were rolling Resident #1 out of the facility. 3. Records showed Resident #4 moved into the facility on and she currently resident on the third floor. An 1823 Health Assessment dated showed she was alert and oriented	A 077		

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A 077	Continued From page 25 times 2. Her diagnoses included: 's ; essential tremor; , , ; , / ; , ; , ; idiopathic , , , , . Resident #4 was independent with eating, self-care (grooming), toileting and transferring and required assistance with ambulation, bathing, and . (Photographic evidence obtained) An interview was conducted on at 2:03 pm with a representative of Resident #4. During the interview she stated that Resident #4 had been , assaulted by a male independent living (IL) resident in the facility. She stated that the incident occurred sometime between and , of 2025. She stated per Resident #4 statement to her, the male IL resident tried to kiss her and put his down her pants. She stated she reported the incident to Employee J, who then immediately explained it had to be reported to the Administrator. She stated the male IL resident resided on the third floor where Resident #4 also currently resides. One representative was then contacted via by phone. She confirmed knowledge of the incident with Resident #4 and relayed a scenario from a visit she had in , . While visiting Resident #4 they were in the parking lot and the male IL resident followed them, stared at them, and made Resident #4 upset. This is when Resident #4 shared the allegation against the male IL resident in his room, and the representative them reported it to Employee J and then the Administrator. During an interview on at 1:43 pm with Employee J she acknowledged that she was made aware of the incident involving Resident #4, which occurred between and , . She confirmed that reports of and/or neglect are to be reported to the state. She stated	A 077		

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A 077	Continued From page 26	A 077		

that she had discussed the allegation with the Administrator. One of Resident #4's representatives wanted to report it to the Administrator, but she was not in the facility. Employee J stated that she contacted the Administrator herself regarding the incident and the response she got what that she would reach out to Resident #4's representative. She stated that she did not submit a written statement nor did she interview either resident. She again stated she contacted the Administrator and was advised that she would reach out to the Resident #4's representative.

On at 11:53 am, the representative for Resident #4 was interviewed again and explained after reporting the incident to Employee J, she received a call from the Administrator within 30 minutes, but she felt the Administrator was nonchalant. The Administrator advised her he was leaving anyway and she didn't want to "cause any waves." The representative said everything was done verbally and nothing was in writing. She said Resident #4 is worried she will get in trouble because the male IL resident appears to have authority in the building.

On at 2:05 pm the Administrator and the Regional Director of Health and Wellness (RDHW) were contacted by phone about concerns identified with Resident #1 and Resident #4. Both of the staff members voiced their disagreement that anything could have been done differently with Resident #1. The RDHW stated that she was not familiar with the requirement to report incidents like this. She was directed to the facility's contract, but said she did not know the details, so the facility's reporting policy section of the Resident Occupancy Agreement was reviewed which indicated

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A 077	Continued From page 27 allegations would be investigated and reported to the state. The Administrator stated that she was "vaguely familiar" with Resident #1. She stated she knew what had been reported by the team. She stated that she was informed by the nurse that Resident #1 had pushed his pendant and it showed he was on the 2nd floor. She stated the nurse informed her that the resident was a . She could not provide any additional information on the matter. The Administrator explained she didn't recognize Resident #4's name when asked. She confirmed she had not reported the incident with Resident #4 and the male IL resident because she did not think it was a report of . She stated she felt it was just a "casual conversation." She again stated that she could not recall if another staff member, past or present, had informed her of the incident. While the Administrator initially denied being advised of any physical contact between Resident #4 and the male IL resident, she confirmed knowledge of the concern with the male IL resident chasing Resident #4 and her representative outside of the facility, and knowledge that Resident #4 was worried the male IL resident would follow her around the facility. She confirmed that she told Resident #4's representative that the male IL resident was leaving the facility and that he was on a waiting list for another community. She stated she became aware of the situation around the first week in , but she had spoken to "a lot of people" when she started and does not remember them all. She denied receiving any reports from staff members. She then recalled Resident #4's representative had come into the office and she was told the	A 077		

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A 077	Continued From page 28	A 077		

male IL resident had tried to kiss Resident #4. She commented that she found this "funny" because the male IL resident had a girlfriend who was living with him. She stated she was unsure of when the kiss between the male IL resident and Resident #4 took place. She referred to the male IL resident as "harmless." She again stated that she recalled being informed by a representative of Resident #4 that the male IL resident had tried to kiss her, but, "it didn't seem urgent." She confirmed that she did not report the incident, adding "I'm not sure what my response was. Normally it would be I'm sorry and I'll look into it." She added. "No, I did not do a formal investigation into it. If it happened in my building [the sister facility where she also serves as the Administrator] I would talk to both parties and do an investigation. I would have given him notice to move out." She confirmed at this facility, that she had not met with either resident to discuss the situation. She confirmed that she had not followed up with Resident #4 or her representatives. She stated she informed a representative that she "would keep an ´ on it and that he would be moving." She stated there was no documentation of that conversation. Again, she stated that she could not recall every conversation that she had since she became the facility's Administrator as there were "people lined up" outside of her door. She stated she believed the incident was reported to her some time in
' .

The RDHW, who was listed on one of the designee letters, explained that she is not at the facility. She traveled between 3 states and didn't have a set schedule. She stated that she was in the facility ´ -23rd 2025. She stated that she had not done any staff training or education. She stated she conducted an orientation with the

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A 077	Continued From page 29 DHW and the assistant DHW. Review of the job description for the Administrator showed they are "responsible to enhance the overall Resident experience through exceptional comprehensive leadership." The job description explained the Administrator was to maintain "unwavering compliance with all local, State and Federal regulations related to operations" for Assisted Living. Photographic evidence obtained. CLASS I	A 077		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints;	A 165		

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A 165	Continued From page 30 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional	A 165		

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A 165	Continued From page 31 who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an adverse incident to the Agency for Health Care Administration for 1 of 6 sampled residents. A report was not filed following a resident receiving care that went against his advanced directives (Resident #1). Additionally, 1 of 6 sampled residents (Resident #4) did not have an allegation of reported to the Department of Children and Families (DCF) when received by facility staff.	A 165		

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A 165	Continued From page 32 The findings include: 1. Review of Resident #1's record showed he moved into the facility on . Resident #1 had a code status of ( ) listed on his demographic sheet. (Photographic evidence obtained) Record review revealed that on at 8:02 am, Resident #1 pressed his pendant for assistance. Progress notes showed staff had difficulty locating him. but when he was found, rescue was called. Hospital records revealed that Resident #1 was provided with life-saving measures by Emergency Medical Services ( ) after the facility staff failed to provide them with his form. (Photographic evidence obtained) Because the team were not advised of Resident #1's code status, life saving measures were initiated which went against his advanced directives. During an interview on at 2:40 pm with Employee L, a Licensed Practical Nurse, she confirmed that she was working the morning of when Resident #1 was found unresponsive. She stated there was a delay in locating Resident #1 as his pendant was showing him in another location of the facility. She confirmed that Resident #1 was found unresponsive in a first-floor men's room. She confirmed that when she eventually located Resident #1, were already performing , , ( ) on Resident #1. She stated that "working on" Resident #1 (providing ,) as they exited the facility. During an interview on at 12:40 pm with Employee O, a dishwasher, he stated he	A 165		

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recalled the incident involving Resident #1. He stated the resident was lying on the bathroom floor. He stated he left the resident and reported the issue to Employee P, Lead Server from the dining room. He stated he and Employee P returned to the restroom where Resident #1 was located. Employee P opened the door to the bathroom stall. He stated the resident was seated with has against the wall and his outstretched. He stated he was unsure if the resident was breathing or not. He stated he asked the front desk receptionist, Employee Q, to notify the nurse. He could not provide a timeframe for the actual events. He stated that nursing was not present during the time he was with the resident.

During an interview on at 12:54 pm with Employee P, a Lead Server, she confirmed observing Resident #1 unresponsive in a men's room on the 1st floor. She could not recall how long she waited for direct care staff to come down to the first floor. She stated that Employee Q informed her that she was not able to reach the nurse. She stated at that time she advised Employee Q to call 911. She stated arrived within minutes. She stated that checked Resident #1 for a , . She stated she heard staff respond that Resident #1 did not have a , and observed them begin , . She stated that Resident #1 was then lifted onto a stretcher with a machine performing , . She stated she observed the nurse and other care staff arrive after rolled Resident #1 out of the facility.

During an interview on at 10:55 am with Employee Q, the Weekend Receptionist, she acknowledged the incident on involving Resident #1. She stated that a member of the dining staff found Resident #1 unresponsive in

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A 165	Continued From page 34 the first-floor men's room. She stated that she made unsuccessful attempts to contact the nursing staff, and she called 911. She did not observe the nursing staff arrive until about the same time arrived. Employee Q explained that upon 's arrival, she gave an worker a copy of the resident's sheet as they went to locate Resident #1. She stated remained with Resident #1 for approximately minutes. She confirmed that she did not provide the team with the yellow form because the resident's code status was listed on the sheet she provided.. She confirmed the yellow forms and sheets are located in a binder at the reception desk, but it was her practice to only provide the sheet. She stated when the nurse arrived, she provided the team with the original yellow form as they were rolling Resident #1 out of the facility. 2. Review of records showed Resident #4 moved into the facility on . Resident #4's 1823 Health Assessment showed she was alert and oriented, and was diagnosed with 's , essential tremor, , , and . Resident #4 was independent with eating, self-care (grooming), toileting and transferring, and required assistance with ambulation, bathing, and . (Photographic evidence obtained) An interview was conducted on at 2:03 pm with two representatives of Resident #4. During the interview they called a third representative who described an incident between Resident #4 and a male independent living (IL) resident who loved on the same floor. In , the representative was visiting and observed the male IL resident following them (she and Resident #4) to the car, and staring at them.	A 165		

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A 165	Continued From page 35 Resident #4 became visibly upset and stated she thought he was gone. At this point Resident #4 confided in the representative that at sometime between and , of 2025, the male IL resident "lured" Resident #4 into his apartment to look at some books, but when she entered, he closed the door and locked it, and the male IL resident tried to kiss her and put his down her pants. Resident #4 told her representatives she fought him off and left but did not tell anyone. When the representative heard this, she made the Administrator aware. The Administrator was interviewed on at 10:26 am by phone. She stated she has not received any complaints about or neglect. She described one call to the Department of Children and Families (DCF) which was unrelated to Resident #4 or the male IL resident. She said she had had no complaints since , . During an interview on at 1:43pm with Employee J, she acknowledged that she was made aware of the incident involving Resident #4, which occurred between and , . She confirmed that reports of and/or neglect are to be reported to the state. Employee J acknowledged one of Resident #4's representatives wanted to report the incident to the Administrator, but she was not in the facility. Employee J contacted the Administrator herself, and the response she got what that she would reach out to Resident #4's representative. She stated that she did not submit a written statement nor did she interview either resident. She again stated she contacted the Administrator and was advised that she would reach out to the Resident #4's representative. A second interview was conducted with Resident	A 165		

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A	Continued From page 36 #4's representative on at 11:53 am. She said Resident #4 has described the incident the same way many times and the only thing that changed is what Resident #4 did in response; sometimes she says she kicked him, sometimes she said she slapped him. She explained she was told by staff members that Resident #4 shouldn't be allowed to socialize with the male IL resident. (This was to clarify a statement made in the earlier interview when the representatives stated they were warned to stay away from him because of he had a history of saying inappropriate comments to women.) She initially reported her concern to Employee R, Evening Receptionist, who urged her to speak with management. Resident #4's representative described the Administrator as "non-chalant" and that she didn't want to "cause any waves" because he was moving out anyway. During an interview on at 3:39 pm with the Director of Health and Wellness (DHW), she stated the Administrator handles resident and family complaints, "verbally. She doesn't write anything down. She handles them in-house. She does a family resident council meeting." On at 2:05 pm, the Administrator the Regional Director of Health and Wellness (RDHW) were contacted by phone about concerns related to Residents #1 and #4. Both the Administrator and RDHW confirmed they did not file Adverse Incident Reports because they did not feel either met the requirement. When the RDHW was directed to the facility's contract, she stated she was not familiar with its content, so the DHW read to her from the facility's reporting policy section of the Resident Occupancy Agreement.	A 165		

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A 165	Continued From page 37 The facility's Resident Occupancy Agreement updated was reviewed. Based on Page 22 Exhibit K , Neglect, , (the reporting of) policy: Every Resident has the right to live in a safe place free from , neglect and , . Therefore, this community establishes and fosters an environment of respect for residents so that no one will become a victim. The contract went on to also include information about reporting to DCF (;3.) Florida Statute mandates that all assisted living personnel be responsible for reporting any suspicion of , neglect, or , . (4.) Should a Resident be in immediate danger staff are instructed to call 911, otherwise, reporting can be done by telephone. Telephone numbers for reporting can be found in common area of the community. Depending on the severity of the report the central hotline will assign an investigator immediately or within 24 hours. Once a call has been made the Administrator or designee should be made aware of the situation. (6)The Executive Director or designee will a) investigate the grievance immediately, b) if staff member involvement, the alleged staff member will be removed from duty pending the outcome of the investigation. (c) as part of the investigation all other residents under the care of alleged staff member will be interviewed. Photographic evidence obtained. The Administrator stated that she was vaguely familiar with Resident #1. She stated she knew what had been reported by the team: that Resident #1 had pushed his pendant and it showed he was on the 2nd floor. She stated the nurse informed her that the resident was a . She could not provide any additional information on the matter.	A 165		

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A 165	Continued From page 38 Regarding Resident #4, the Administrator stated that she "didn't recognize the name." She confirmed she had not reported the incident with Resident #4 and the male IL resident because she did not think it was a report of . She stated she felt it was just a "casual conversation." She again stated that she could not recall if another staff member, past or present, had informed her of the incident.. She stated the only thing she recalled was being advised that the male IL resident had chased Resident #4 and her representative outside of the facility, and she told them that the male independent living resident was leaving the facility and that he was on a waiting list for another community. She stated the representative of Resident #4 reported that when she and the resident were together, the male independent living resident would follow Resident #4 around. She stated she became aware of the situation around the first week in , . She stated that she had spoken to "a lot of people" when she started and does not remember them all. She then stated that she believed the daughter of Resident #4 had come into the office and she was told the male IL resident had tried to kiss Resident #4 She stated, "it didn't seem urgent." She confirmed that she did not report the incident adding "I'm not sure what my response was. Normally it would be I'm sorry and I'll look into it." She added. "No, I did not do a formal investigation into it. If it happened in my building [the sister facility where she also serves as the Administrator] I would talk to both parties and do an investigation. I would have given him notice to move out." She stated that she had not met with either resident to discuss the situation. She confirmed that she had not followed up with Resident #4 or her representatives. She stated there was no documentation of that conversation.	A 165		

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A 165	Continued From page 39 Again, she stated that she could not recall every conversation that she had since she became the facility's Administrator as there were "people lined up" outside of her door. CLASS II	A 165		