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
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 third revisit to a re-licensure survey was conducted at Senior Gardens Senior Residence from to . Deficiencies were identified at the time of the survey. Class I deficiency was found at tag A-0025. A Class I deficiency is a deficiency that the agency determines present a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , or to a resident receiving care in a facility. The Class I non-compliance began on . The facility Administrator was notified on . The census at the start of the survey was 151 residents. Seven residents experienced during a span of five months. One resident experienced a which resulted in . One resident experienced a and sustained a . Five more residents experienced that required to be transferred to the hospital.	{A 000}		
A 025 SS=J	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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian,	A 025		

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A 025	Continued From page 2 health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision for seven out of 41 sampled residents (Residents # 10, # 11, # 15, # 16, # 38, # 39 and # 40), all seven residents suffered with injuries, and were transferred to the hospital; Resident # 10 , because of a hematoma due to the , Resident # 11 suffered a right , Resident # 15 suffered a broken , Resident # 16 suffered a on left side of forehead and Resident # 39 sustained a on her right requiring stitches, Resident # 38 sustained to of the and Resident # 40 sustained a forehead. Findings included: A review of the Agency Intake Report System (AIRS) revealed that from to there were seven incident reports regarding residents with that had been taken to the hospital for further evaluation and treatment (Residents # 10, # 11, # 15, # 16, # 38, # 39 and # 40). A review of facility' records showed : 1- Resident # 10 on at 2:37 AM suffered	A 025		

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A 025	Continued From page 3 a in her room and was found with a left with and was sent to the hospital via rescue for further evaluation, she was diagnosed with a left side of and ; she at the hospital on due to a hematoma. On she had been found with forehead hematoma on right side and could not recall what happened, she cannot explain if she hit her with a surface, she was sent to the hospital. On resident had slid down her bed around 8:45 PM, right arm observed. Health assessment completed on had her diagnosed with 's in Situ of Skin of Unspecified Part of with (Moderate) and Essential Primary . She required supervision with ambulation, eating and transferring. Assistance with bathing, , eating and toileting. On at 2:33 PM the Director of Nursing stated regarding when Resident # 10 was found with a hematoma on her , "She had not . She used to walk better before, we think that she was going to the bathroom and hit her but we do not know how." Stated, "Now she needed supervision for ambulation and redirection." On at 3:02 PM Staff F stated, "She used to wake up a lot at night. Sometimes we would take her to the nurse station until she wanted to go to bed, that night she had not woken up. I was working with 2 home health , one of them told me she had felt a noise in Resident # 10's room, we went in there and she was sitting between the bathroom door and the room door, which are too close. The resident had a little	A 025		

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A 025	Continued From page 4 around her left , we helped her and called rescue, they came and said that it was nothing important, but they took her to the hospital." 2- Resident # 11 suffered a in his room on while trying to transfer from the wheelchair to his bed, he was transferred to the hospital via rescue and was diagnosed with left , and required surgery. He had a previous on and the right , also requiring surgery. Health assessment completed on had him diagnosed with , unspecified of right , difficulty in walking, , hyperplasia, with behavioral disturbance, , type II, , , major , , , deformans of unspecified bone, personal history of and without residual , fatigue and . He was identified with risk, used wheelchair for ambulation and required assistance with ambulation, bathing, , self-care, toileting and transferring and was independent for eating. On at 11:40 AM Staff L stated that on Resident # 11 could not be found after dinner, he was not in a designated area at the end of the hallway where residents are placed before they are returned to their rooms. Stated that the Resident was not in his room and he was later found in the room next to his lying on the floor and complaining of , on his and , area. Also stated that the Resident may have gotten and went into the wrong room. 3- Resident # 15 suffered a on and	A 025		

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A 025	Continued From page 5 was found from her , she was sent to the hospital and diagnosed with a , she came on . She suffered another on and sustained a right and a to right , she was not hospitalized. Health assessment completed on had her identified as risk for , she was independent with eating and required supervision with ambulation, bathing, , grooming, toileting and transferring. She had been diagnosed with , , , , , , , of , diverticulosis of small , , of without . 4- Resident # 16 suffered a at 11 PM when she lost balance transferring from wheelchair; redness at of , she was sent to the hospital and came on . Suffered another on at 10:40 PM, she was found sitting on floor and had a left forehead with ; sent to hospital and returned on . Health assessment completed on had her identified as risk, she required supervision for eating and assistance with ambulation, transferring, toileting, grooming, bathing and . She had been diagnosed with , right , , , . 5- Resident # 38 suffered a on at 7:15 PM, she was found on the floor with to of ; she was sent to hospital and returned on . Health assessment completed on had her identified as risk and required Assistance with bathing, , and grooming; she was independent	A 025		

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A 025	Continued From page 6 with ambulation, eating and transferring and required supervision with toileting. She had suffered a previous on and sustained a right side , and small bump at occipital ; sent to hospital; and returned the same day with , noted. 6- Resident # 39 suffered a on at 11 AM; she lost her balance and hit her with the corner of the dining table sustaining a of the right , , she was sent to the hospital and returned on at 6 PM with butterfly stitches applied to the right , ; she had had a previous on and suffered a , . Health assessment completed on had her identified as risk, was independent with ambulation and eating, supervision with grooming and needed assistance with bathing, , toileting and transferring. She was diagnosed with type 2 , , , , , , following , personal history of transient episode and without residual , without , , , atherosclerotic of native , without pectoris, , major , , , , and , of vocal and . - On at 10:00 AM observed Resident # 39 with a new injury, she had a hematoma on right side of the and forehead that was resuming (different colorations, yellow, green, purple and red, and her right was and red), apparently about a week old, a aid with a little was observed on her forehead.	A 025		

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A 025	Continued From page 7 -The stages of hematoma healing, detailed by the National Library of Medicine (NLM) through its various publications, involve the initial clotting and , followed by the reabsorption of and tissues over several days to weeks for minor hematomas, or several months for larger ones. This process typically progresses from a red or blue color to green and yellow before resolving, though the exact timeline and stages depend on the hematoma's size, depth, and location. -A review of Resident # 39 progress notes revealed that on at 8:50 PM, resident was sitting at south wing nurse station, staff was supervising and stated resident was sitting in her wheelchair when she leaned forward and forward. -On at 10:00 AM on interview Resident # 41, who shares the room with Resident # 39, stated that Resident # 39 frequently in the room and there is never no one there to assist her. -On at 1:35 PM the Administrator stated, "Resident # 39 was in the activities room in the south wing and there was an employee with the residents, she got up from the wheelchair, lost her balance and , the staff could not catch her." 7- Resident # 40 suffered a on after losing her balance and was sent to the hospital with a forehead. Health assessment completed on had her identified as precautions, was independent with ambulation and eating, required supervision with grooming, toileting and transferring and assistance with	A 025		

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A 025	Continued From page 8 bathing and . She had been diagnosed with unspecified ; mild ; generalized ; of ; acquired absence of left and , major . On at 2:31 PM the Administrator stated, "The supervision tag has to do with the ?" A review of the facility's precautions policy showed, "The purpose of the precautions policy of the facility is to reduce and the risk of patient harm resulting from ." On at at 9:41 AM Staff E (Supervisor) stated regarding if she had enough staff in her shift, "Now I do because one started today and she is going to be in training with me 3 days. Because of the thing with immigration and the working permit, 4 of my staff were let go, their positions got filled up fast. It happened about 4 or 5 months ago." On at 10:18 AM Staff M (HHA) stated, "I think we need more people." On at 10:44 AM Staff O (CNA) stated, "I have been working here for 3 months. At least 2 more staff are needed." On at 11:40 AM Staff Q (HHA) stated, "For the past weeks is 3 of us working on the west side, before it was only 2. Now the staff was increased and there is enough. The staff was increased about 4 or 5 weeks ago, it was less staff before." On at 9:42 AM Staff S (HHA) stated that she had worked at the facility for about a month	A 025		

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A 025	Continued From page 9 and her schedule was 7 A to 3 P. When asked why are there so many ? she stated, "Sometimes they get weak, by the time we get to them it's too late" On at 10:15 AM Staff T (HHA) stated that she had worked at the facility for about a month. "Yes, we need more staff. We do what needs to be done, but it would be better for the residents if there were more of us. When there are 5 staff, we have 14 residents each. When there are 6 staff, we have 11 residents" On at 11:29 AM Staff F (Supervisor/HHA) stated, "in the between the south and west wing, we are 6 or 7 staff and the supervisor. In my opinion we need one more staff." Class I	A 025		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill	A 056		

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A 056	Continued From page 10 organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort	A 056		

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A 056	Continued From page 11 to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow the Health Care Provider orders when assisting residents with self-administration of medications for one out of 41 sampled residents (Resident # 10). Findings included: On at 10:09 AM spoke to Resident #	A 056		

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A 056	Continued From page 12 10's relative on the phone, she stated that the Resident was supposed to have a Rivastagmine patch applied daily to her skin and that on , she stated that at the hospital the resident had a patch with the date written on it and there were no other patches on her skin (photographic evidence sent by relative). According to the National Library of Medicine, " patches are used to treat (a that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in and) in people with (a that slowly destroys the memory and the ability to think, learn, communicate and handle daily activities). is also used to treat in people with 's (a system with symptoms of slowing of movement, , shuffling walk, and loss of memory). is in a class of medications called inhibitors. It improves mental function (such as memory and thinking) by increasing the amount of a certain natural substance in the . Be sure to remove the patch before you apply another one." A review of Resident # 10's record revealed that the health assessment completed on had the resident diagnosed with 's , in Situ of Skin of Unspecified Part of , , with , (Moderate) and Essential Primary , , A review of Resident # 10's medication observation record (MOR) revealed that she had an order for 9.5mg/24hr Patch daily. Revealed that different staffs had signed the	A 056		

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A 056	Continued From page 13 patch as applied on , and ; but only one from had been found on her body. On at 1:20 PM, the Administrator stated, "That's interesting." Class III	A 056		
A 079 SS=G	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to	A 079		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 14 facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. 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 of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 15	A 079		

counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 16 Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure sufficient staffing was available to meet the scheduled and unscheduled needs. Seven residents	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 17 experienced from through . As a result of those , seven of the 41 residents (#10, #11, #15, #16, #38, #39, and #40) sustained injuries such as , bleeds, , hematomas, and and due to injuries were hospitalized. Findings included: Observations Review of the staffing schedule revealed for the week of to there was a census of 151 residents in the facility and the direct care staff worked for a total of 1440 hours. Review of the staffing schedule revealed for the week of to there was a census of 151 residents in the facility and the direct care staff worked for a total of 1440 hours. Review of the staffing schedule revealed for one Registered Nurse (RN), two medication technicians, and ten Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM. one Registered Nurse (RN), two medication technicians, and seven Home Health Aides (HHA assigned to the floor. Further review of the staffing schedule revealed six Home Health Aides (HHA were scheduled during the overnight shift, from 11 PM-7 AM. On revealed for one Registered Nurse (RN), two medication technicians, and ten Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM. one Registered Nurse (RN), two medication technicians, and seven Home Health Aides (HHA) assigned to the floor.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 18 Further review of the staffing schedule revealed seven Home Health Aides (HHA were scheduled during the overnight shift, from 11 PM-7 AM. On revealed for one Registered Nurse (RN), one medication technician, and five Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11:PM, one Registered Nurse (RN), one medication technicians, and five Home Health Aides (HHA assigned to the floor. Further review of the staffing schedule revealed four Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM. On the staff schedule revealed two Registered Nurse (RN), one medication technician, and nine Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM, two Registered Nurse (RN), one medication technician, and five Home Health Aides (HHA assigned to the floor. Further review of the staffing schedule revealed six Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM. On , one Registered Nurse (RN), two medication technicians, and eight Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM, one Registered Nurse (RN), two medication technicians, and seven Home Health Aides (HHA) assigned to the floor. Further review of the staffing schedule revealed six Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM. On 25 the staff schedule revealed one Registered Nurse (RN), two medication	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 19	A 079		

technicians, and ten Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM, one Registered Nurse (RN), two medication technicians, and nine Home Health Aides (HHA) assigned to the floor. Further review of the staffing schedule revealed six Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM.

On the staff schedule revealed one Registered Nurse (RN), two medication technicians, and twelve Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM, one Registered Nurse (RN), two medication technicians, and nine Home Health Aides (HHA) assigned to the floor. Further review of the staffing schedule revealed six Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM.

On the staff schedule revealed one Registered Nurse (RN), two medication technicians, and twelve Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM, one Registered Nurse (RN), two medication technicians, and ten Home Health Aides (HHA) assigned to the floor. Further review of the staffing schedule revealed five Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM.

On the staff schedule revealed one Registered Nurse (RN), two medication technicians, and twelve Home Health Aides (HHA) were scheduled during the morning shift, from 7 AM-3 PM, and the afternoon shift, from 3 PM-11 PM, one Registered Nurse (RN), two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 20 medication technicians, and nine Home Health Aides (HHA) assigned to the floor. Further review of the staffing schedule revealed six Home Health Aides (HHA) were scheduled during the overnight shift, from 11 PM-7 AM. Review of the staffing levels showed: through = 1565 staff hours through = 1580 staff hours. through = 1328 staff hours through = 1296 staff hours through = 1620 staff hours through = 1716 staff hours. through = 1722 staff hours through = 1812 staff hours. Review of the staffing schedules and facility census showed that the facility had 145 residents on , a census of 149 on , a census of 150 residents on , a census of 153 on , a census of 154 on , and , a census of 156 on and at these times and was required to have 665 hours weekly. While this ratio met the minimum requirement identified in the statute, staffing was insufficient to meet the scheduled and unscheduled needs of residents. Review of the facility's list of residents who need supervision and assistance with Activities of Daily Living (ADLs) revealed that 92 residents, 66 needed assistance with ambulation, 108 residents needed assistance with bathing, 104 residents needed assistance with , 72 residents needed assistance with toileting and 78 residents needed assistance with transferring. A review of facility incident reports, nursing notes, and resident records showed that seven residents between , through ,	A 079		

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	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 21 2025. In an interview on 9:41 AM Staff E was asked if there was enough staff? She stated, " Now, I do feel there is enough staff. I asked for an increase in staff, and they gave me someone. She started today and she is going to be training with me for three days. There was lack of staff because of the thing with immigration and the work permits. Around , and , they had to release the staff and replace them. The four of my staff were let go and their positions were filled quickly, like the next day. We communicate with the supervisors, MedTech and Administrative staff on the walkie talkies. The direct care staff call on their phone to communicate with us. When the staff comes in the morning they are assigned to an amount of residents for bathing. They bathe them, groom them and dress them. Any of the direct care staff assist them with everything else. The staff are assigned to the same residents during their shift, so the residents won't get disoriented or . All staff assist residents who need assistance with transferring in a wheelchair, assistance with ambulating, and eating." At 9:52 AM, Staff E stated, "During the 7:00 AM to 3 :00 PM shift we have about ten residents assigned to the four staff members on the West side and hospice does the other 32. If hospice needs assistance the facility staff helps them when they need it. When hospice leaves at 6:00 PM, we have five direct care staff from the 3:00 PM to 11:00 PM shift to help with the 40 residents and the 32 hospice residents totaling 72 residents. We have a MedTech , the supervisor which covers both (West and South) sides, and four home health aides (HHA's) during that time. On the South side we have four staff members	A 079		

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	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 079	Continued From page 22 which included one MedTech, and three home health aides (HHA). On the 11:00 AM to 7:00 AM shift we have three staff on each wing and one supervisor to cover both sides. on at 10:18 AM Staff AM was observed in room taking residents a bath. In an interview on at 10:20 AM Staff M stated, "I was assigned to 10 to 11 residents. I come and bath them and when I am done, I help the other staff. I think we need more people." In an interview on at 10:30 AM Staff N stated, "I have been here two weeks. They give me a list of residents assigned. I have 10 of them. I bathe them, groom them, and dress them. I take them to activities, and the dining room. Not all walk on their own I have four that uses a wheelchair." In an interview on - at 10:44 AM Staff O stated, "I have been working here for three months. I get me assignment in the morning. In my opinion they need at least two more people to work. They had some people leave because of immigration. I don' t have a permanent assignment because I work on both sides (South & West). They give me the residents that I am familiar with and that are familiar with me." In an interview on at 10:51 AM Staff P stated, "I have been working here for four years, I used to work 11:00 PM to 7:00 AM for 2 ½ years and have been working 7 AM to 3 PM for 1 ½ years. I have 12 residents, I do bathing, feeding, toileting, and grooming; I I think the staffing is fine, we have 14 staff in total on 7 AM to 3 PM shift." In an interview on 0827/24 At 11:40 AM Staff Q stated, "When I get to the facility I get the list with	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 079	Continued From page 23	A 079		

my assignment. For the past weeks 3 of us have been working on the west side, before it was only 2. At night we check that the residents are ok, we change the diapers 2 or 3 times and as necessary. Now the staff was increased and there is enough. If a resident wakes up constantly we sit him or her with a staff. Sometimes different residents wake up at the same time and it is harder for us. The staff was increased about 4 or 5 weeks ago, it was less staff before."

In an interview on 08.27/25 at 10 am resident interview with Resident #41 who resides in with the Resident #39.
In an interview on at 10:00 AM Resident #41 states that Resident #39 frequently in the room and there is never no one there to assist her. Resident #39's no longer communicate with her , but she tries a lot to assist herself.

In an interview on 08.27/25 at 10:20 am with Staff T stated, she has been employed with the facility for one month, And works the 7 am -3 PM shift. I assist the residents in everything they need, in the morning they take them to the dining area as a part of our routine to the bathroom as well. After lunch they do activities, bathing and changing the residents as needed.

When asked how she assist the resident, she stated "with caution" we always call someone to assist with lifting the client. Staff T stated, regarding enough staff "sure they get the help whenever they need it, and do she think it enough employees to assist them. Staff T stated that "Do I want help?" Right now, we are in need of people right now, but we always get the job done. Everyone do their best and is going to help. But in reality, the more staff the better. The residents would be better supervised and better

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 079	Continued From page 24 assisted if there was more staff. When asked if she felt overwhelmed, she stated "yes". When there are 5 of us here, we have 14 residents when there are 6 of us, we have 11 residents." Class II	A 079		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable.	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 162}	Continued From page 25 (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ˘ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ˘ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˘ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an ˘ recipient, a copy of the Department of Children and Families form Alternate Care Certification for Optional State	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 162}	Continued From page 26 Supplementation ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 162}	Continued From page 27 license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate health assessment for three out of 41 sampled residents (Residents # 12, # 13 and # 14). Findings included: On at 9:11 AM a Registered Nurse from Hospice stated that they had 3 residents with , and those 3 records were reviewed: 1- Resident # 12 had a health assessment completed on that stated that the resident had no , 3 or 4 , , a review of the hospice care plan from revealed that the resident had a , in the that first appeared on and received daily care. 2- Resident # 13 had a health assessment completed on that stated that the resident had no , 3 or 4 , , a review of the hospice care plan from revealed that the resident had a , in left upper that first appeared on and an , on right and received daily care. 3- Resident # 14 had a health assessment completed on that stated that the resident had no , 3 or 4 , , a review of the hospice care plan from revealed that the resident had a , in the area that first appeared on and an , on	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 08/28/2025

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SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 162}	Continued From page 28 right and received daily care. On at 2:32 PM the Director of Nursing stated regarding the health assessments, "Those are recent ." Uncorrected Class III	{A 162}		
A 165 SS=D	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; 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	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 165	Continued From page 29 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 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	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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A 165	Continued From page 30 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 observation, interview, and record review the facility failed to file an adverse incident report for one out of 42 (Resident #39) sampled residents. Resident #39 at the facility on and was hospitalized. Findings included: A review of the Adverse Incident Report (AIRS) database found no report of a on . On at 11:30 AM Resident #39 was observed with a hematoma on right side of the and forehead that was resuming (different colorations, from greenish to bloody red and her right , was and red), apparently about a week old, a aid with a little was	A 165		

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A 165	Continued From page 31 observed on her forehead. In an interview On at 10 :00 AM Resident #41 who resided in with the Resident #39, stated, "Resident #39 frequently in the room and there is never no one there to assist her. Her no longer communicate with her , but I try a lot to assist herself." Record review of documented: "On at 8:50 PM, resident was sitting at south wing nurse station, staff was supervising and stated resident was sitting in her wheelchair when she leaned forward and forward. Nurse on duty assessed resident, right forehead was observed. No loss of (LOC). Resident was awake, alert and oriented X 1 to person. Call placed to Emergency Medical Services ( )/911 immediately for further evaluation. arrived, assessed resident , vital signs within normal limits. Resident was transferred to [Hospital] emergency room at 6:50 PM in stable condition. The granddaughter was notified by phone about incident. Copy of med list and sheet provided. On 4:30 PM, resident returned from hospital at 3:00 PM via ambulance. Primary care physician (PCP) was notified via phone about incident and hospitalization. Medication list reconciled at the hospital. no acute injuries, no . Resident vital signs within normal limits. Resident denied acute , or discomfort at this time. precautions implemented. " Class III	A 165		