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
	AL11967186	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HOUSE-OAKWOOD	4407 MILLWOOD ROAD SPRING HILL, FL 34608

(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 (complaint numbers 2025010623 and 2025011679) was conducted at Ann's House-Oakwood on /2025. The facility had deficiencies at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the 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	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 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on staff interviews, video review, resident record review and facility policy and procedure review, the facility failed to assess one resident (#1) out of 6 sampled residents out of 11 current residents for a change of condition and notify his physician when a staff member broke and the resident's ⌄ during assistance with care. The findings include: During an interview on at 9:31 am with the facility administrator, she acknowledged that the caregiver, Employee D Resident #1's left ring ⌄ during an altercation	A 025		

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A 025	Continued From page 2 with him during care. She stated that she was on vacation when the incident occurred. The resident's son had set up a video camera in his father's room that captured the incident. He provided her a copy of the video. She brought up the video on her phone for review by the survey team. She confirmed that the incident happened on at approximately 6:30 pm. The video was reviewed by the survey team and confirmed that Employee D did take hold of Resident #1's and bent his ring and little to the point of fracturing the ring on his left during care (Copy obtained). During an interview on at 10:20 am with Employee C, caregiver, she stated she was not working at the time of the incident. It was a Sunday, and she does not work Sundays. She came to work on Monday, and saw Resident #1's when he was lying in bed. His was hanging down off the bed. She did not think it was a problem because he had in his , and they would often swell if he did not keep them elevated. She took a picture of his and sent it to the administrator who was on leave and out of the country. Later Resident #1's was observed to not be anymore. She did not work on the 15th and when she returned to work on the 16th she observed that his was not . She worked on the 17th too and his was not . She later realized that the picture she sent to the administrator did not go through to her. When she returned to work on the 21st she was shown the video the resident's son had of the incident and that is the first time that she knew of what happened to him.	A 025		

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A 025	Continued From page 3 During an interview on at 11:17 AM with the facility administrator, she stated that the delay in care was due to the direct care staff, Employee C elevating the resident's when she observed his being on . After the went down no one noticed his being or any problem with it. The resident did not express . When she returned from her trip on she followed up with the resident's son who had taken a picture of his father's and sent it to her. She brought the photo up on her phone and showed it to the survey team (Copy obtained). Resident #1's appeared , and the ring and little appeared to be out of . She stated that the hospital staff told the resident's son that because it had been so long since the was broken, they could not put it in place and he would have to see an Orthopedic physician to have it set right. They put a brace on it temporarily and sent him to the facility. The son then decided to move him home and discharged him. During an interview with employee E on at 12:35 pm she observed Resident #1's on when she came to work. She alerted her co-worker, Employee C. They provided interventions of icing the and elevating it. The went down. The resident did not express any signs of . When she came to work on she did not notice any . She worked again on and when she came to work at 7pm Resident #1's son was returning him from the hospital. His was , and bandaged. She was told his was broken. During an interview on at 1:54 pm	A 025		

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A 025	Continued From page 4 with the facility administrator she stated that she was visiting a foreign country when the incident happened and her phone got intermittent service in that country. When Employee C, medication technician and caregiver, identified that Resident #1's was , she sent the administrator a photo of his . The photo did not transmit to her phone for several days and she was unaware that his was . She returned from her trip on and spoke with the resident's son who informed her of the incident and the results of the of his father's . She stated that she nor her staff conducted a systematic review of the rest of the clients after the incident. She did not think it would be necessary since they all did not require the same level of assistance with care as Resident #1 did. Review of the hospital records dated imaging results revealed it read: [Resident #1] is a male who presents with and obvious deformity to left fourth . Patient is coming from a facility. Per they noted the approximately 5 days ago. No imaging has been performed. XR 3 or more views. Left. Findings: , displaced, intra- , angulated of ring , phalanx base. No Procedure: Closed . Local used. 1% without , , . Multiple attempts by provider and attending ER physician for reduction that was unsuccessful. The has been out of place for approximately 5 days. specialty to be consulted at this time (Electronic copy obtained). Review of the clinical record for Resident #1 revealed his Agency for Health Care Administration Health Assessment form dated	A 025		

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A 025	Continued From page 5 read: Resident #1 admitted . Medical History/Diagnoses included: or behavioral status: . Assistance with ambulation, bathing, , self-care, toileting and transferring. Poses no danger to self or others. Does not require 24-hour nursing or care. Needs can be met in an assisted living facility. Needs assistance with medication self-administration (Electronic copy obtained). Review of the facility Incident Report Policy and Procedure revealed it read: Purpose: To provide data for whenever any unusual situation occurs. Policy: All incidents will be reported to the administrator. Completed incident forms must be turned into the administrator by the person completing the incident form within 24 hours of the occurrence. An incident form must be completed whenever any unusual situation occurs with residents, staff or visitors. Incidents that require reporting include and carelessness in the performance of a procedure that led to potential or actual resident injury. An adverse incident form must be also completed should the outcome of the incident be a or of bones or joints. Any condition that required 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. , neglect or , as defined in Florida Statute (Electronic copy obtained). Class II	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 6 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 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;	A 030		

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A 030	Continued From page 7 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.- (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 030		

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A 030	Continued From page 8 (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. (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	A 030		

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A 030	Continued From page 9 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 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	A 030		

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A 030	Continued From page 10 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 Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.-	A 030		

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A 030	Continued From page 11 (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 staff interview, video review, resident interview, resident record review and facility policy and procedure review, the facility failed to ensure that one resident (#1) out of 6 sampled residents out of 11 current residents was free from when a staff member the resident's during assistance with care. The findings include: During an interview on at 9:31 am with the facility administrator, she acknowledged that the caregiver, Employee D Resident #1's left ring during an altercation with him during care. She stated that she was on vacation when the incident occurred. The resident's son had set up a video camera in his father's room that captured the incident. He provided her a copy of the video.	A 030		

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A 030	Continued From page 12 She brought up the video on her phone for review by the survey team. She confirmed that the incident happened on at approximately 6:30 pm. She stated that the employee involved had been terminated immediately. The video was reviewed. The date stamp was at 19:31:00 hours. At 19:31:31 Employee D was observed with disposable gloves on her to be attempting to take an brief off of Resident #1 who was observed lying in his bed in his room. Resident #5 was observed in the room standing next to the of the bed, not assisting Employee D, but talking to Resident #1. Resident #1 was observed to be yelling at both the employee and Resident #5 to leave him alone and get out of his room. Employee D can be heard to say to Resident #1 "Okay" but does not leave the room. She continued to struggle with Resident #1. He was observed to have both tightly gripping the left arm of Employee D at her and area. She removes the soiled brief with her right and dropped it on the floor leaving Resident #1 naked from the waist down. Employee D can be heard to say to Resident #1 "You see how your are ?" as she is attempting to put his up on the bed. Resident #5 then comes around to the of the bed and assists Employee D in putting Resident #1's up on the bed. She then assists Employee D to pull the brief up under the resident. Resident #1 was still heard yelling for them to leave his room. At 19:31:36 Employee D turned to Resident #1 and pulled his away from her with her right . As she is doing so, a cracking sound can be heard. She was observed to have taken hold of the last two on his left and bent them backward. Resident #1 then let go of	A 030		

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A 030	Continued From page 13	A 030		

her and grabbed hold of her left upper arm with both of his as she continued to place the new brief on him. He then started hitting Employee D with his fist. Resident #5 was heard to say, "Stop it, you're hurting her." He replied "I'm gonna hurt you". Employee D and Resident #5 continue to put socks on Resident #1's and cover him with a blanket. He is heard to tell them to "Go away." Resident #5 told him "Go to bed. Go to bed now, we're leaving." Resident #5 came around to the of the bed and stated "How the hell ....You've got some moves [Resident #1]. You're incredible". Employee D covered him with a blanket. She asked him if he was and he told her to "Go away. Go away." She pointed her at him and told him if he got to cover himself (Copy obtained).

During an interview on at 10:20 am with Employee C, caregiver, she stated she was not working at the time of the incident. It was a Sunday, and she does not work Sundays. She came to work on Monday, and saw Resident #1's when he was lying in bed. His was hanging down off the bed. She did not think it was a problem because he had in his , and they would often swell if he did not keep them elevated. She took a picture of his and sent it to the administrator who was on leave and out of the country. Later Resident #1's was observed to not be anymore. She did not work on the 15th and when she returned to work on the 16th she observed that his was not . She worked on the 17th too and his was not . She later realized that the picture she sent to the administrator did not go through to her. When she returned to work on the 21st she was shown the video the resident's son had of the incident and that is the first time that she knew of

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	AL11967186	A. BUILDING: _____ B. WING _____	C 08/27/2025

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A 030	Continued From page 14 what happened to him. During an interview on at 11:17 AM with the facility administrator, she stated that the delay in care was due to the direct care staff, Employee C elevating the resident's when she observed his being on . After the went down no one noticed his being or any problem with it. The resident did not express , . When she returned from her trip on she followed up with the resident's son who had taken a picture of his father's and sent it to her. She brought the photo up on her phone and showed it to the survey team (Copy obtained). Resident #1's appeared , and the ring and little appeared to be out of , . She stated that the hospital staff told the resident's son that because it had been so long since the was broken, they could not put it in place and he would have to see an Orthopedic physician to have it set right. They put a brace on it temporarily and sent him to the facility. The son then decided to move him home and discharged him. During an interview on at 1:54 pm with the facility administrator she stated that she was visiting a foreign country when the incident happened and her phone got intermittent service in that country. When Employee C, medication technician and caregiver, identified that Resident #1's was , she sent the administrator a photo of his . The photo did not transmit to her phone for several days and she was unaware that his was . She returned from her trip on and spoke with the resident's son who informed her of the incident and the results of the of his father's . She stated that she nor her staff conducted a	A 030		

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A 030	Continued From page 15 systematic review of the rest of the clients after the incident. She did not think it would be necessary since they all did not require the same level of assistance with care as Resident #1 did. During an interview on at 10:55 am with medication technician and caregiver, Employee B, she stated that she worked with Resident #1 almost daily for two years. He was not combative with her. If he refused to cooperate with her she would leave him alone and come later and try again. "He was a stubborn man, but he could be reapproached and usually was then ". She worked with Employee D in the last few months before the incident. "She acted like she was my boss. She would not allow me in the room to help her do care". She stated that she always had a two-person assist to provide care with Resident #1, but Employee D always did it by herself. She did not see her providing care with him often. She was not working at the time of the incident. During an interview on at 2:20 pm with Resident #5 she stated that she has lived at the facility for 8 years. She likes living here. She does some work for the administrator like cleaning up after the meals. She is glad to have the job and does not want to lose it. She stated that on the evening of at approximately 6:30 pm she was asked by Employee D to assist her with Resident #1. She was about to go to bed but decided to go help her. Resident #1 resided in another part of the building. She went over there and went in the room while Employee D was changing Resident #1's brief. She stated she did see Resident #1 naked from the waist down. She stated she did	A 030		

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A 030	Continued From page 16 not like helping with care and she felt uncomfortable about being asked to do so. She has told the administrator that she does not want to be asked to help with that kind of care anymore. She did not know why she was asked to help. She stated when she saw their arms flailing about and heard them yelling at each other she did not know what do and stated, "I felt bad for [Resident #1]". She stated that she did not put her on Resident #1. She filled out a witness statement for the Sheriff's office when they came to investigate. She asked if she was "in trouble". She does not want to get in trouble for being in the room with Employee D and Resident #1. Review of the hospital records dated imaging results revealed it read: [Resident #1] is a male who presents with and obvious deformity to left fourth . Patient is coming from a facility. Per they noted the approximately 5 days ago. No imaging has been performed. XR 3 or more views. Left. Findings: , displaced, intra- , angulated of ring , phalanx base. No . Procedure: Closed . Local used. 1% without . Multiple attempts by provider and attending ER physician for reduction that was unsuccessful. The has been out of place for approximately 5 days. specialty to be consulted at this time (Electronic copy obtained). Review of the clinical record for Resident #1 revealed his Agency for Health Care Administration Health Assessment form dated read: Resident #1 admitted . Medical History/Diagnoses included: or behavioral status:	A 030		

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A 030	Continued From page 17 . Assistance with ambulation, bathing, , self-care, toileting and transferring. Poses no danger to self or others. Does not require 24-hour nursing or , care. Needs can be met in an assisted living facility. Needs assistance with medication self-administration (Electronic copy obtained). Review of the facility Policy and Procedure For Neglect and , revealed it read: Purpose: To establish a uniform policy and procedure for reporting and responding to all , neglect or , allegations. Policy: It is the policy and responsibility of [Facility] to report all allegations of neglect and or , to the administrator or the Department of Children and Families as soon as it is observed or suspected. It is a violation for retaliatory actions to be taken against any reporter. Allegations are to be reported within four hours of the allegations. If there is an allegation or indication of physical injury ... or any situation where a victim's health is in question, the administrator or her designee shall immediately seek appropriate medical attention. Once the report is made to the administrator an internal investigation will ensue. Review of the facility Policy and Procedure or Suspected By Employees read: Policy; Any suspected will be reported immediately to the administrator. Procedure: Following a report, an internal investigation will be conducted by the administrator. Results of the investigation will be forwarded to Adult Protective Services if warranted. The employee involved will be placed on a Leave of Absence without pay until results of the investigation are complete. Founded charges will result in an immediate termination and notification of the appropriate	A 030		

Agency for Health Care Administration

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A 030	Continued From page 18 agency. Class II	A 030		