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
	AL11964808	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COTTAGE OF OVIEDO	445 ALEXANDRIA BLVD. OVIEDO, FL 32765

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A 000	Initial Comments A complaint #2025009840 and generator monitoring surveys were conducted from to . The complaint was substantiated. Savannah Cottage of Oviedo had Deficiencies identified at the time of the survey. Class I deficiencies were identified at A0025 Resident Care - Supervision and at A0077 Staffing Standards - Administrators The facility failed to ensure the temperatures in the common areas and two dining rooms were always at 81 degrees F. The Class 1 noncompliance began at 10:15 AM. The census at the start of the survey was 27. The Administrator was notified of the Class 1 deficiencies on at 1:30 PM. The facility failed to provide care and services appropriate to meet the needs of residents by failing to monitor the general health, safety, and physical well-being of all 27 residents present when the temperature exceeded 81 degrees Fahrenheit inside the facility. The facility failed to conduct fire watch as directed by the fire inspector on . The administrator failed to oversee the operation and maintenance of the facility including provision of appropriate care when the facility did not monitor the general health, safety, and physical well-being of residents when facility temperatures exceeded 81 degrees Fahrenheit.	A 000		

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A 025	Continued From page 1	A 025		
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 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.	A 025		

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A 025	Continued From page 2 (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide appropriate care and services appropriate to meet the needs of residents by failing to monitor the general health, safety, and physical well-being of all 27 residents present when the temperature exceeded 81 degrees Fahrenheit (F) inside the facility. The facility failed to conduct fire watch as directed by the fire inspector on . Findings: On Saturday at 10:20 AM, a tour of the facility was conducted. The facility was very warm. The temperature in the common area was 83.3 degrees F. The activity area was noted at 82.7 degrees F. The dining room on the left was 82.5 degrees F and the dining room to the right was 82.7 degrees F. A wellness check of all residents was completed.	A 025		

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A 025	Continued From page 3 On at 10:35 AM, resident #1 was observed lying on his bed in his apartment. It was notably warm in his room. Resident #1 stated he felt hot. The temperature was 78.4 degrees F taken with Agency for Health Care (AHCA) issued thermometer. There was no thermostat in the resident's room to adjust the temperature. On at 11:13 AM, the Administrator said the air conditioner was installed yesterday. The air had been out for "a bit". When asked for a time frame she said a couple of weeks because they had been waiting on parts. A request was made to review a policy for excessive temperatures in the facility. She confirmed she could not provide a policy for temperatures above 81degrees Fahrenheit. On at 11:30 AM, Caregiver A said she had never seen any portable air conditioning (A/C) units in the facility. She added the residents' rooms had A/C. However, the resident rooms are locked once they have gotten them up for the day. On at 2 PM, an interview with Maintenance Director was conducted. The last time the portable A/C units were used was a month ago. He stated one A/C unit was not working, and it was replaced and there was one other unit that still was not working. He explained this unit would supply cooling to the common areas and dining rooms. He said he removed the portable A/C units because a resident was "messing with them." A request was made for the portable A/C units to be put in place to cool the common areas and dining rooms. On at 2:55 PM, Caregiver F stated she	A 025		

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A 025	Continued From page 4 had never seen portable a/c units set up before. On at 10:35 AM, the Resident Care Director (RCD) recalled the a/c had not worked since she started 4 months ago. She acknowledged the Administrator was aware of this. The RCD confirmed she had not seen portable air conditioners being used in the facility before. at 1:43 PM, resident #6's sister stated the a/c had not worked in the facility for about 4 months. The maintenance Director provided a calendar for , and which documented temperatures taken daily on weekdays in the common areas starting . The following temperatures were documented in degrees F (were taken with ACHA issued thermometer): - 83.1 - 81.6 - 80.1 - 81.1 - 82.5 - 81.2 -no temperatures taken - 81.3 - 83 - 81.1 - 81.2 - 81.4. - no temperatures taken - no temperatures taken. - 83.1 - 82 - 81.6 - no temp - no temp.	A 025		

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A 025	Continued From page 5 - 83.2 - 80.8, - 82.3 - 81.6 There was no documentation that temperatures were taken on Saturday and Sundays (weekends). On at 2:37 PM, the common area was measured at 86.1 degrees F. The activity area was 84.7 degrees F. There were 10 residents in the area at the time. On at 2:55pm Caregiver F advised she had never seen the portable A/C units set up before. On at 3 PM, two portable a/c units were set up in the activity room, but they were not running. The Maintenance Director said when they were turned on, the breaker would trip. He continued to work on getting them started. On at 4:15 PM, the right dining room was at 85.1 degrees F when dinner was being served. The left dining room was 84.9 degrees F. The activity room was 83 degrees F (temperatures were taken with an ACHA thermometer). On temperatures were taken at 5 PM and were taken with an AHCA thermometer which revealed the following temperatures: " Common area- 85.4 degrees F " Activity area- 84.5 degrees F " D hall- 82.2 degrees F " Thermostat in hall read- 82 degrees (Photo) F " Middle hall- 80.2 F " Room A2- 80 degrees F	A 025		

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A 025	Continued From page 6 " Room A3- 78.8 degrees F " Room A5- 79.3 degrees F " B hall thermostat- 78 F " Room B1- 77.5 degrees F " Room B2- 76 degrees F " B4- 77 degrees F " B5- 76 degrees F " B7- 78.8 degrees F " B8- 79.8 degrees F " Right dining room- 81.8 degrees F " Left dining room- 82 degrees Ft On at 6:06 PM, during an interview with the A/C man, he noted his team replaced a roof top unit on . He explained they mistakenly fired the unit while it was off, and the compressor overheated which caused the unit not to function. On at 4:10 PM, the Administrator was asked to provide a plan for maintaining acceptable building temperatures and repairing the A/C units. On at 11:10 AM, the Administrator stated she could not provide a written plan for maintaining adequate temperatures. She said the Regional Director would provide it. On at 11:05 AM, an interview was conducted with the Administrator and the Regional Director. The Regional Director said she was not made aware of the A/C units not working until , when the State Agency arrived at the facility. The administrator was asked what she did to attempt to decrease the temperatures in the common area of the facility starting . The Administrator said she called the A/C company, but it took 4 weeks to get the equipment needed on the roof where the A/C was located. She noted	A 025		

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A 025	Continued From page 7 the equipment was placed on but the equipment . The Administrator confirmed she did not notify the Regional Director, the State Agency, or the Department of Emergency Management, during the 4 weeks the A/C was not functioning. She acknowledged the supplemental portable a/c units were not used and she did not explain why not. 2. On at 11:13 AM, the Administrator stated room D2 had a leak which prompted the fire alarm to activate. On at 1:40 PM, the Director of Nursing (DON) was asked about the fire inspection. She confirmed there was no documentation of a passed inspection because the fire inspector was just there on . The DON stated she was not aware the facility was on Fire Watch. A review of the Fire Inspection report revealed the facility failed due to chapter 13 fire protection systems. Action: provide Fire Watch until system is operational and approved by Fire Marshal's office. On at 3 PM, the Administrator provided a Fire Watch form. Directions at the top of the form noted to do hourly watch and every half hour watch for residents in rooms. The Fire Watch started at 12 AM on and was documented as completed hourly. There were no half hour checks documented. The Administrator said they were doing the half hour checks with temperature checks. It was pointed out to her that the directions for the Fire Watch were imposed by the Fire Inspector. On at 8:24 AM, the Fire Inspector returned an email confirming due to another false	A 025		

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A 025	Continued From page 8 alarm call, the facility was put on Fire Watch on . He verified the facility was still on Fire Watch. He noted the roof was to be replaced last year, but it was not addressed. He added, the roof was leaking causing water to leak into the fire alarm system causing false calls and troubles on the system. He believed there was water leaking into the electrical system that posed a fire risk. He further explained the water also posed a mold risk. On at 11:30 AM, the Administrator confirmed the Fire Watch was not being conducted every half hour when residents were in their rooms as directed. She acknowledged staff who conducted Fire Watch did not sign the forms correctly making it difficult to confirm the watch was conducted. (Photo Evidence Obtained) Class I	A 025		
A 030 SS=G	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	A 030		

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A 030	Continued From page 9 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; 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 .	A 030		

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A 030	Continued From page 10 (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) 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.	A 030		

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A 030	Continued From page 11 (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 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	A 030		

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A 030	Continued From page 12 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 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	A 030		

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A 030	Continued From page 13 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.- (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	A 030		

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	AL11964808	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COTTAGE OF OVIEDO	445 ALEXANDRIA BLVD. OVIEDO, FL 32765

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A 030	Continued From page 14 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 observation, record review and interview, the facility failed to honor residents' right to live in a safe, comfortable living environment by failing to immediately respond to air conditioning (A/C) outage when facility temperatures were above 81 degrees which could negatively affect all residents in the facility at the time of the survey. 2) The facility failed to ensure fire watch was implemented as directed by the Fire Marshal on . 3) The facility failed to ensure to keep a clean and decent living environment by not ensuring the bathroom and the only shower in hall A clean and usable. Findings: 1. On at 10:15 AM, during a tour of the facility, temperatures in the facility exceeded 81 degrees Fahrenheit (F). The common area was 83.3 degrees F. The activity area was 82.7 degrees Fahrenheit. The right dining room was 82.7 degrees F, and the left dining room was 82.5 degrees F. There were no portable air conditioners a/c units, window A/C units, or chillers seen during the tour (temperatures taken with AHCA thermometer). On at 11:13 AM, the Administrator said the air conditioner was installed yesterday as it had not been working for "a bit". She explained it had been a few weeks since they were waiting on	A 030		

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A 030	Continued From page 15 parts. When asked to review a policy for excessive temperatures in the facility, she stated she could not provide a policy for temperatures above 81 degrees F. On at 11:30 AM, Caregiver A said she had never seen any portable A/C units in the facility. On at 2:55 PM, Caregiver F stated she had never seen portable a/c units set up before. On at 2 PM, the Maintenance Director confirmed the air conditioning unit that cooled the common areas and dining rooms were not working. He said the Administrator asked him to document facility temperatures and provided a temperature log. The log noted either the Maintenance director or the Maintenance Assistant took the temperatures in the common area at noon and at 4 PM. Review of the temperature log noted temperatures were only taken on weekdays and not on weekends starting , and ending . On 19 out of 21 days, the temperature exceeded 81 degrees F (temperatures taken with AHCA thermometer). On at 2:37 PM, the common area was 86.1 degrees Fahrenheit. The activity area was 84.7 degrees F. There were 10 residents in the area. At 4:15 PM, the right dining room was 85.1 degrees F when dinner was being served. The left dining room was 84.9 degrees F, and the activity room was 83 degrees F (temperatures taken with AHCA thermometer). On at 2:55pm Caregiver F advised she had never seen the portable a/c units set up	A 030		

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A 030	Continued From page 16 before. On at 4:15pm right dining .1degrees Fahrenheit when dinner was being served. The left dining .9 degrees Fahrenheit and the TV/activity room was 83 degrees Fahrenheit (temperatures taken with ACHA thermometer). On at 2:40 PM, the Administrator said there were 12 A/Cc units, and it was not the same unit that broke every time. She confirmed the facility did not keep any logs of A/C preventative maintenance. On at 10:35 AM, the Resident Care Director (RCD) recalled the A/C had not worked since she started 4 months ago. She acknowledged the Administrator was aware of this. The RCD confirmed she had not seen portable air conditioners being used in the facility before. On at 2:30 PM, the Regional Director verified the A/C repairs were approved in . She did not explain why the repairs were not completed. On at 11:05 AM, the Administrator was asked what she did to attempt to decrease the temperatures in the facility common areas starting on . The administrator said she called the A/C company, but it took 4 weeks to get the equipment needed on the roof where the a/c was located. She noted the equipment was placed on but the equipment . She acknowledged the supplemental portable A/C units were not used and she did not explain why not.	A 030		

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A 030	Continued From page 17 2. On at 11:13 AM, the Administrator stated room D2 had a leak which prompted false fire alarms to activate. Review of the Fire Inspection report conducted revealed the facility was placed on Fire Watch. The Administrator confirmed she did not send the Fire Watch to the State Agency area office. She said the Fire Marshal told the Maintenance Director they did not have to do Fire Watch. There was no documentation provided to indicate the facility was no longer on Fire Watch. On at 3 PM, the Administrator provided a Fire Watch form. Directions at the top of the form noted to do hourly watch and every half hour watch for residents in rooms. The Fire Watch started at 12 AM on and was documented as completed hourly. There were no half hour checks documented. On at 11:30 AM, the Administrator acknowledged Fire Watch was not being conducted every half hour when residents were in their rooms as directed by the Fire Marshall. She confirmed staff conducting Fire Watch were not signing the form correctly making it difficult to confirm the watch was conducted. On at 1:40 PM, the Director of Nursing (DON) acknowledged there was no pass inspection because the Fire Marshall was just there two days ago, on . 3. On at 10:52 AM, while conducting temperature checks of the facility the bathroom in hallway A was observed with feces on the toilet and on the floor. Caregiver B stated the bathroom had been this way for months. She said the Maintenance Director turned off the water and	A 030		

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A 030	Continued From page 18 the electricity in the entire bathroom area. Caregiver B revealed the House Manager and the DON were aware of the conditions in the bathroom and shower area but neither of them addressed it. Caregiver B, noted housekeeping staff, were aware of the bathroom conditions, but they would not clean it either. On at 10:45 AM, the DON said she was aware of the bathroom and shower area being unclean for the past few weeks and said the House Manager was taking care of it. On at 11:37 AM, the Administrator stated she was not aware of the bathroom having feces on the toilet, in the toilet and on the floor. She was not aware there was no running water or electricity in the A hallway bathroom. On at 10:00 AM, the House Manager explained she knew about the unclean condition in the A hallway bathroom since when it was brought to her attention, but it slipped her memory to have someone clean the area. On at 11:11 AM, while conducting room checks it was observed in resident room (A5) the windowsill was covered in dirt. At this time, Caregiver B said the housekeeping staff did not do a good job with cleaning the facility and these are the conditions the residents had to live in. Caregiver B added, this was a shameful situation, and the residents should not have to live in such filth. On at 12:36 PM, resident #15's wife noted the facility had roaches. She stated that on while in her husband's room she opened his drawer to put some clothes away and a swarm of roaches came out of his drawer on to	A 030		

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A 030	Continued From page 19 her. She explained she immediately told the House Manager and the DON. They both assured her that they would contact the pest control company to have his room immediately sprayed. On at 1:26 PM, the Maintenance Director said there had been complaints from resident family members about rodents and roaches and the last one was on . Photographic evidence obtained Class II	A 030		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable	A 036		

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A 036	Continued From page 20 medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide services in a manner that reduced the risk of transmission of . This failure could potentially affect all residents, staff, and visitors. Findings: On at 2:55 PM, Caregiver F stated resident #9 was recently diagnosed with Corona 2019 (COVID). She added resident #12 now had a wet and was not feeling well. A tour of the facility did not reveal any resident including resident #9 in isolation. There was no signage at the entrance indicating possible COVID outbreak. Review of resident #9's record revealed she was admitted to the hospital on with a diagnosis of COVID . She returned to the facility on . On at 10:10 AM, resident #8 was observed in the common area coughing and had a runny . Caregiver D said there were several residents who currently had a , and no one had been checked for COVID. On at 11:33 AM, the Administrator was asked how long resident #9 was , before going to the hospital. She replied, "not	A 036		

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A 036	Continued From page 21 long". When asked to elaborate she replied, "a couple of days maybe". She confirmed resident #9 was not , the Department of Health had not been notified, and there was no facility protocol in place to monitor other residents for possible outbreak. The Administrator said they were just keeping an , on everyone. Class III	A 036		
A 077 SS=J	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 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	A 077		

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A 077	Continued From page 22 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 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	A 077		

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A 077	Continued From page 23 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. (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	A 077		

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A 077	Continued From page 24 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 Administrator failed to oversee the operation and maintenance of the facility including the provision of appropriate care when the facility did not monitor the general health, safety and physical well-being of residents when facility temperatures exceeded 81 degrees Fahrenheit (F). Findings: On Saturday at 10:20 AM, a tour of the facility was conducted. The temperature in the common area was 83.3 degrees F. The activity area was noted at 82.7 degrees F. The dining room on the left was 82.5 degrees F and the dining room to the right was 82.7 degrees F. A wellness check of all residents was completed. On at 10:20 AM, the Maintenance Director stated he was asked to take temperatures in the facility starting on , , , and ending on . He explained that the Administrator asked him and the Maintenance Assistant to take the temperatures because there were 2 A/C units not working. He noted one unit supplied cooling for the kitchen, and the other was for the residents' common areas.	A 077		

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A 077	Continued From page 25 The maintenance Director provided a calendar for , and , which documented temperatures taken daily on weekdays in the common areas starting , , . The following temperatures were documented in degrees F: - 83.1 - 81.6 - 80.1 - 81.1 - 82.5 - 81.2 -no temperatures taken - 81.3 - 83 - 81.1 - 81.2 - 81.4. - no temperatures taken - no temperatures taken. - 83.1 - 82 - 81.6 - no temp - no temp. - 83.2 - 80.8, - 82.3 - 81.6 During staff interviews, it was revealed the residents were locked out of their rooms once they had been dressed in the morning. The residents then spent the entire day in the common areas, activities room and dining rooms where the temperatures were over 81 degrees F. On at 11:05 AM, in an interview with Administrator and the Regional Director of	A 077		

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A 077	Continued From page 26 Operations (RDO), the RDO said she had started working at the facility 2 weeks ago. She was not made aware of the air conditioning not working until , the day the State Agency arrived at the facility. At 11:10 AM, the Administrator was asked what she did to decrease the temperatures in the facility common areas starting . She said she called the A/C company, but it took 4 weeks to get the equipment needed on the roof to install a new A/C unit. The Administrator confirmed she did not notify the RDO, the State Agency, or the Department of Emergency Management. She confirmed the supplemental portable air conditioning units were not used. She acknowledged she did not have a policy or procedure for what to do if temperatures in the facility exceeded 81 degrees F. The air conditioning unit was not fixed until five days after the State Agency arrived at the facility. Class I	A 077		
A 152 SS=G	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents	A 152		

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A 152	Continued From page 27 must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. Failed to ensure air conditioning (A/C) unit functioned properly in the common/activity area. Findings: On at 10:15 AM, agency staff arrived at	A 152		

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	AL11964808	A. BUILDING: _____ B. WING _____	08/20/2025

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A 152	Continued From page 28 the facility. The facility did not have a working A/C unit in the memory care facility. The common area by the facility front door temperature was 89.6 degrees Fahrenheit at 11:15 AM (taken with an AHCA issued thermometer). On at 10:52 AM, the bathroom located in hallway A had no running water, and the lights were observed not working. There were dried feces on the side of the toilet bowl, dried feces in the toilet, and dried feces on the floor. On at 10:52 AM, Employee B was asked why the bathroom has dried feces on the toilet, in the toilet and dried feces on the floor. Employee B stated the bathroom has been this way for months. On at 11:37 AM, the Administrator was asked if she was aware of the bathroom in hallway A, having feces on the toilet, in the toilet and on the floor, she stated no. On at 111:37 am, the administrator was asked if she knew about the following concerns related to housekeeping and maintenance concerns within the memory care facility: 1. The administrator was asked if she was made aware of the bathroom in hallway A, having feces on the toilet, in the toilet and on the floor. 2. The administrator was asked about no running water in the same bathroom as in the shower. 3. The electricity not working in the same hallway as the bathroom and she stated no. 4. The administrator was asked about the skylight located in the common area, the walls are located near the ceiling, having what seemed to be water stains on the walls and a black substance on the walls and a black substance on the walls. 5. The administrator was asked if there had been	A 152		

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A 152	Continued From page 29 any recent leaks in the skylight area for the facility 6. The administrator was asked what the water markings on the walls near the ceiling under the skylights were. 7. The administrator was asked what the black spots were observed on the wall near the ceiling under the skylights. 8. The administrator was asked about the missing baseboards, and she stated that the floors had just been replaced a few months ago. She stated maybe three months ago give or take. On at 12:52 PM, resident #4's wife stated her husband was admitted to the facility on , she stated that her husband's room seemed warm, but she thought it was just due to the sun bearing in on his room at the time. Resident#4's wife stated that it was not until she asked an employee why it was so hot that she was told the facilitates A/C has not worked in the building for months or for a better part of the year. On at 1:17 PM, Employee A was asked how long the facility has been without A/C. Employee A stated it has been going on for at least months, could be a year, maybe more. She stated that since we are in the hotter months it has been very unbearable for the residents as well as the employees. She was asked has the facility provided spot cooler or fans for the residents who sit in the common area she replied no. On at 1:22 PM, Employee D stated the A/C had not worked in almost a year. She added that family members had questioned the administrative staff but were told it was being worked on, or they were in the process of getting estimates so they can go with the best offer.	A 152		

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A 152	Continued From page 30 On at 2:07 PM, Employee F was asked how long the facility has been without A/C she stated that she could not remember a time when the facility had A/C. She was asked to give an approximate timeline for the A/C being out. Employee F stated the Ac has been out for about 10 months. Employee F was asked if she had ever seen the space coolers in the common areas before she said, "No and if they had them why didn't they put them out for the residents". On at 2:12 PM Employee E noted the facility had been without A/C for about a year. She explained administrative staff knew about it, but nothing was done. Employee E explained that at least 4 families had taken their loved ones out of the facility because of these conditions. On at 2:44 PM, the Director of Nursing (DON) stated two portable A/C units would not start and maintain a cool environment because the circuit breakers were constantly being blown or tripped due to an overload on the circuit breaker. The DON went said the facility maintenance staff were working on getting the problem resolved. On at 3:49 PM, the DON was made aware of the temperature in the common areas was 86.9 degrees F. She observed the temperature on the thermometer and stated, "Wow that's hot". On at 5:10 PM, the temperature in the common area was 84.2 degrees F. The C hallway temperature was 82.4 degrees F. The D hallway temperature was 83.7 degrees F. Two resident rooms in the D hallway were above 81 degrees F, Room D2A and D2B temperature was 82.5 degrees F, in room D5 was 81.5 degrees F.	A 152		

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A 152	Continued From page 31 On at 12:10 PM, resident #5's son was visiting with his father. He stated the A/C had been out of commission for approximately months. He stated that every time he mentions it to the Administrator, DON and House Manager, he was told the facility is either getting quotes/estimates so the facility can address the matter. On at 12:36pm Resident 15's wife stated that the facility has roaches. She stated that on while in her husband's room she opened his drawer to put some clothes in a swarm of roaches came out on her. Resident 15's wife stated that she immediately told employee H and the DON, they both assured her that they would contact the pest control company to have his room immediately sprayed. On at 1:27pm The maintenance director was asked if there had been any complaints from resident's family members about rodents and roaches, he said yes. He was asked when the last time the facility had been notified of roaches, he said on Friday . He was asked does the facility keep a log of when the exterminator comes into the facility and he said yes. On at 1:43 PM, resident 6's sister stated the A/C had not worked in the facility for about 4 months. She stated the maintenance staff were taking the temperature one afternoon and she inquired why it was being conducted, and they told her it was because the facility had no A/C, and the temperature was 86 degrees F in the common area. Photographic Evidence Obtained	A 152		

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A 152	Continued From page 32 Class II	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary	A 160		

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A 160	Continued From page 33 emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C.,	A 160		

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A 160	Continued From page 34 issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated 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 maintain satisfactory fire inspection reports. Findings: Review of a fire inspection conducted on revealed the facility failed due to chapter 13 fire protection systems. Action: provide fire watch until system is operational and approved by Fire Marshall office. On at 1:40 PM, the Director of Nursing	A 160		

Agency for Health Care Administration

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A 160	Continued From page 35 was asked about the fire inspection. She explained there was no passed inspection report as the fire inspector was at the facility two days ago, on and they had not received any documentation. (Photo Evidence Obtained) Class III	A 160		