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
	AL11969407	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAGRASS VILLAGE OF FLEMING ISLAND	1949 E W PKWY FLEMING ISLAND, FL 32003

(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 An unannounced change of ownership survey with complaint investigation (complaints 2024010390, 2025007920, and 2025010721) was conducted at Seagrass Village of Fleming Island on , , 2025. The facility was found to have deficiencies at the time of the survey.	A 000		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

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A 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff exorcized their responsibilities to document according to their internal policy and job description, for 1 of 2 sampled residents.	A 078		

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A 078	Continued From page 2 Findings include: Review of the facility policy titled "Incident Reporting" found the following procedure listed: "The Executive Director or Designee will investigate the incident and document any appropriate corrective and preventive actions. The Executive Director and Director of Resident Services will inservice the associates in corrective actions to prevent future incidents." Photographic evidence obtained. Review of the Executive Director's Job Description showed it was signed by the Executive Director on . Point 17 of the Job Description stated, "Oversees all resident services to ensure all required service and documentation is completed timely and in accordance with community policy and AHCA regulations." Photographic evidence obtained. The Executive Director was asked on at 12:30pm to provide documentation surrounding the investigation, and corrective actions, of an allegation involving Resident #2, in which the Clay County Sheriff's Office (CCSO) was also involved. She explained at that time that the CCSO did not have findings from their investigation. She was asked to report the issue in the Adverse Incident Reporting System (AIRS) by her supervisor but did not think it needed a separate internal investigation. During an interview on at 10:00am, the Director of Resident Services (DORS) stated she and the Executive Director came to the facility after CCSO arrived to investigate an allegation for Resident #2. They left without reporting any findings and reported they were	A 078		

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A 078	Continued From page 3 going to close the case. She also confirmed the Department of Children and Families (DCF) did an investigation but had no findings. She confirmed speaking with Resident #2 about the allegation. When asked for documentation, the DORS stated, "With all the DCF and the police involved, I didn't do it. I would have called the ED and the ED would have reached out to the family, which we did. I'll be honest, it slipped my mind." During an interview on at 11:45am, the Executive Director confirmed an internal investigation was not documented. "When I reached out to my immediate supervisor, the Vice President of Operations, I received their guidance. I did not look at the policy. She explained she thought that CCSO and DCF's lack of findings would have been enough, along with the AIRS report, but she has learned it was insufficient. She explained she spoke to the employees involved, "I just don't have any documentation of what was involved with those conversations." Class III	A 078		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the	A 093		

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A 093	Continued From page 4 National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic	A 093		

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A 093	Continued From page 5 diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˽ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any	A 093		

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A 093	Continued From page 6 resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a 3-day supply of nonperishable food was on at all times for the 82 current residents of the facility. Findings include: During an observation on at 11:30 AM, the emergency food supply was viewed with the Culinary Services Director. Among the food supply were 3 cases of single serving apple juice, one case with an expiration date of , one case with an expiration date of , and one case with an expiration date of . There were also 6 flats of various flavors of canned soda with expiration dates of observed among the inventory. During an interview on at 11:40am, the Culinary Services Director stated "I'm in here all of the time. It's dated when it's received and items are good for a year after receipt." Upon further questioning, the Culinary Services Director denied verifying the actual expiration dates of the items.	A 093		

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A 093	Continued From page 7 During an interview on at 10:15am, the Executive Director stated "I expect the items to be removed when they are expired." Class III	A 093		