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
	AL11922279	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF EASTBROOKE	201 SUNSET DRIVE CASSELBERRY, FL 32707

(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
ZZ821 SS=D	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

AHCA Form 3020-0001

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

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	ZZ821		

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ZZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on facility reviews and interviews, the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident for 1 of 7 sampled residents (#1). Findings: A record review of resident #1 revealed a facility admission on . A 1823 health assessment indicated a medical history of , , need for assistance with personal care, and . Review of a facility note on at 8:14 PM documented by the Administrator read, I received a call about resident #1 not wanting to change into clothing that the POA provided. I reached out to the director of nursing (DON) she needed to call the POA for guidance. When she called the POA, he threatened with physical violence to her. I came to the facility along with the DON and notified the Casselberry Police Department. The Administrator was asked to provide an incident report for law enforcement arrival to the facility.	ZZ821		

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ZZ821	Continued From page 4 On at 5:50 PM, the Administrator stated, I did not file an incident report for law enforcement arrival to the facility. I didn't know I needed to. The DON called them from her home, and they told her to come to the facility to take her statement. (photographic evidence obtained) Class III	ZZ821		
A 000	Initial Comments A complaint investigation #2025012349 and generator monitoring was conducted at Gardens of Eastbrooke on . The facility had deficiencies at the time of the survey.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of	A 052		

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A 052	Continued From page 5 being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the	A 052		

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A 052	Continued From page 6 physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , ⌄ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups,	A 052		

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A 052	Continued From page 7 and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's	A 052		

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A 052	Continued From page 8 control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews unlicensed care staff A failed to follow proper medication - assistance with self-administration of an improper med pass for 2 sampled residents (#2, #3). Findings: Observations of 2 med passes revealed the following: On at 10:21 AM, observation revealed unlicensed caregiver A perform proper hygiene before, during and after the med pass. She acknowledged the resident ensuring he was in his room. She reviewed the medication observation record (MORS) for resident #2's medications which consisted of: 6 AM , 6 AM , 8 AM , 8 AM , , 8 AM , 8 AM , ER, 8 AM , , 8 AM , and 8 AM B-1. The medications were pre-popped into a medicine cup at the cart outside of the presence of resident #2 in the hallway and updated the MORs before administration of the medications. The medicine cup along with the bubble packs and a cup of water were taken into the resident's room. Adding "I'm taking the meds with me just in case he asks me what he's taking." The unlicensed caregiver did not state the name or dose of the medications, handing the cup of pills and water to the resident who self-administered without any assistance.	A 052		

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A 052	Continued From page 9 The unlicensed caregiver was made aware that a 2nd med pass observation was required and asked if the next med pass would occur around lunch time. On at 10:36 AM, unlicensed caregiver A stated, you can watch me now because I've got care to do" and I'm going to be all over the place. I have more medications that are due now. I can do them 1 hour before or 1 hour after the scheduled time. On at 10:45 AM, unlicensed caregiver A performs proper hygiene before, during and after the med pass. She acknowledged the resident ensuring she was in her room. She reviewed the MORs for resident #3's medications which consisted of: 8 AM , 8 AM , 7 AM , Sod, 8 AM , Sod DR, 8 AM , , 8 AM CRYS, 8 AM HBR, 8 AM B-1, and 8 AM . The medications were pre-popped into a medicine cup at the cart outside of the presence of resident #3 in the hallway and updated the MORs before administering. The - scheduled for 8 AM was removed from the cart and the staff wrote the date on the yellow label located above resident #5's name. The medicine cup along with the bubble packs, inhaler, Iprat- , and a cup of water were taken into the resident's room. The unlicensed caregiver did not state the name or dose of the medications, handing the cup of pills to the resident who self-administered without any assistance drinking from her own water bottle. Resident #3 asked "Did I receive my , medication?" The unlicensed caregiver replied, "your , yes, it's in there." "It takes a few	A 052		

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A 052	Continued From page 10 minutes before it kicks in." The staff proceeded to remove the inhaler from the box belonging to resident #5, shaking several times before handing to resident #3. Resident #3 also shook the inhaler several times before proceeding to place in her administering 2 puffs. Unlicensed caregiver A was asked if she received her 6-hr. initial training, explained the med pass process, administered at the wrong times, and why did she administer resident #5's inhaler to resident #3. On at 11:06 AM, unlicensed caregiver A stated, I've received my 6-hr. training in person for passing meds. I was trained to wash, state the name and dose of the medication and to check if the medication could be crushed. If so, the information would be stated on the MORs. The unlicensed caregiver stated "I was nervous" when asked why she didn't state the name and dose of the medications and prepare in the presence of the residents. Adding, "please don't get me fired." Sometimes they don't get the meds on time. No, I don't tell the nurse or Administrator when I'm behind on passing meds. I mean, the residents are getting them. The unlicensed caregiver replied, "Oh wow, when asked why she administered resident #5's inhaler to resident #3, adding they take the same medication. I guess I didn't pay attention. Unlicensed caregiver A completed 6hr self-administration of assistance with medications on but failed to follow the facility's approved policy dated which states giving medication directly to the resident at the time the medication is to be taken. The Administrator and DON were made aware of	A 052		

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A 052	Continued From page 11 the improper med pass and asked if unlicensed caregiver A informed her of the medication error. On at 12:00 PM, the DON stated no, she didn't tell me. I wish I would have known sooner. I would have pulled her off the med cart. On at 2 PM via phone, the Administrator, DON, and Corporate Nurse confirmed the findings. (photographic evidence obtained) Class III	A 052		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be	A 056		

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A 056	Continued From page 12 contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or	A 056		

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A 056	Continued From page 13 complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to follow physician orders for 2 of 2 sampled residents (#2, #3) as required. Findings: Observations of 2 med passes revealed the following: On at 10:21 AM, observation revealed unlicensed caregiver A review the medication observation record (MORS) for resident #2's medications which consisted of: 6 AM , 6 AM , 8 AM , 8 AM	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922279	A. BUILDING: _____ B. WING _____	09/10/2025

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A 056	Continued From page 14 , , 8 AM , 8 AM , ER, 8 AM , , 8 AM , and 8 AM B-1. The unlicensed caregiver was made aware that a 2nd med pass observation was required and asked if the next med pass would occur around lunch time. On at 10:36 AM, unlicensed caregiver A stated, you can watch me now because "I've got care to do and I'm going to be all over the place'. I have more medications that are due now. I can do them 1 hour before or 1 hour after the scheduled time. On at 10:45 AM, unlicensed caregiver A reviewed the MORs for resident #3's medications which consisted of: 8 AM , 8 AM , , 7 AM Sod, 8 AM , Sod DR, 8 AM , , 8 AM CRYS, 8 AM HBR, 8 AM B-1, and 8 AM . The 8 AM 160 4.5 - inhale 2 puffs by 2 times a day, rinse after each dose inhaler belonged to resident #5. Unlicensed caregiver A was asked why didn't resident #2 and #3 receive their medications at the scheduled time and administered resident #5's inhaler to resident #3. On at 11:06 AM, unlicensed caregiver A stated, I had to feed someone and do care during the med pass time. Sometimes, they don't get the meds on time. No, I don't tell the nurse or Administrator when I'm behind on passing meds. "I mean, the residents are getting them." The unlicensed caregiver replied, "Oh wow, when asked why she administered resident #5's inhaler	A 056		

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A 056	Continued From page 15 to resident #3, adding they take the same medication. I guess I didn't pay attention. Are you going to report me? Review of the facility's undated Medication Program stated all medication errors will be reported immediately to the Administrator (or designee). Errors may include the following: Wrong Resident - any dose of medication administered to the wrong resident. Wrong Time - any dose of medication administered more than one hour before or after the designated time of administration as ordered by the physician (i.e. written on the MOR). The Administrator (or designee) will notify the Resident's physician and follow the physician's instructions. The Administrator (or designee) will notify the Resident (when appropriate) and the Resident's Responsible Person. The Administrator (or designee) will document the error and the physician's instructions on the Resident's chart. Where required, the state regulating agency will be notified. Unlicensed caregiver A completed 6hr self-administration of assistance with medications on but did not follow the physician orders to administer the medications at the right time and to the right person. The Administrator was made aware of the improper medication pass, and the DON was asked if unlicensed caregiver A informed her of the medication error. On at 12:00 PM, the DON stated no, she didn't tell me. I wish I would have known sooner. I would have pulled her off the med cart. On at 2 PM via phone, the	A 056		

Agency for Health Care Administration

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A 056	Continued From page 16 Administrator, DON, and Corporate Nurse confirmed the findings. (photographic evidence obtained) Class III	A 056		