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
	AL11963839	A. BUILDING: _____ B. WING _____	C 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT CITRUS	2341 W. NORVELL BRYANT HIGHWAY LECANTO, FL 34461

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A 000	Initial Comments A complaint investigation (complaint number 2025013881) was conducted at The Reserve at Citrus on September 22, 2025 through September 24, 2025. Deficiencies were identified at the time of survey. A Class I deficiency was found at Tag A0030. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. On 08/31/2025, at approximately 4:30 AM, a resident used her pendant to call for assistance. Two staff responded to the resident's room and observed the resident lying on the floor. Staff assisted the resident to her bed. At approximately 4:50 AM, staff checked on the resident again. The resident was observed to be unresponsive. The staff member called on the radio for another staff member for assistance. The second staff member was certified in cardiopulmonary resuscitation (CPR). Neither staff member initiated CPR or used the facility's automated external defibrillator (AED). The resident, who was documented to be a full code status [full code means medical support should be provided, including CPR, if a resident has no heartbeat and is not breathing], did not survive. The Class I noncompliance began on August 31, 2025. The facility's Administrator/CEO was notified of the Class I noncompliance on September 24,	A 000		

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A 000	Continued From page 1 2025 at 9:20 AM. The census at the start of the survey was 72. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 030	59A-36.007(5) FAC; 429.28(1-2) 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 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; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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A 030	Continued From page 2 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. Alcohol and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident abuse, neglect, and exploitation; 6. Administrative and housekeeping schedules and requirements; 7. Infection 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 restraints. (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	A 030		

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A 030	Continued From page 3 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 abuse and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the	A 030		

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A 030	Continued From page 4 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 appointments for health care services, the provision of or arrangement of transportation to health care appointments, and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, 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	A 030		

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A 030	Continued From page 5 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 restraint, 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, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability 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	A 030		

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A 030	Continued From page 6 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 Abuse Hotline operated by the Department of Children and Families, and Disability 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 incompetent or incapacitated under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents' rights were honored by not initiating cardiopulmonary resuscitation (CPR) and failing to implement the facility's policy and procedures when the resident was found unresponsive and absent of life, Resident #1. This has the potential to affect 41 residents at the facility who are a full code status [full code means medical support should be provided, including	A 030		

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A 030	Continued From page 7 CPR, if a resident has no heartbeat and is not breathing]. Findings include: Review of Resident #1's resident record revealed she was admitted to the facility on 05/18/2023 and discharged on 09/02/2025 (the date the resident's belongings were removed from her apartment.) The record did not contain documentation of a Do Not Resuscitate Order (DNRO.) Resident #1's Emergency Information Data Summary form documented, "Code Status Full Code." Review of a progress note dated 08/31/2025 at 6:37 AM documented, "Resident was found deceased approximately 5 AM. Called brother left Voice Mail." Review of a facility Resident Incident Report documented an incident that occurred on 08/31/2025 at 4:30 AM involving Resident #1. The report listed the incident type as "Alleged Fall." The description of the incident was described as, "She stood up to use the bathroom, legs were shaky gave out. Fell to floor." The assistance given was described as "Assisted back into bed, changed her, performed range off [sic] motion, resident asked to be given a few mins [minutes] to relax and to come back in a bit. Left pendant within reach." Review of a second facility Resident Incident Report documented another incident involving Resident #1 that occurred on 08/31/2025 at 5:07 AM. [This report later documents that 5:07 AM was the time Emergency Services arrived at the facility, not the time of the incident.] The report listed the incident type as "Significant Change of	A 030		

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A 030	Continued From page 8 Resident Condition (with or without 911)." Under the incident type it is handwritten "unresponsive." The report states there were no apparent injuries, but Resident #1 was observed lying in bed unresponsive. The report states that Emergency Services was called at 4:55 AM, and they arrived at 5:07 AM. During an interview on 9/22/25 beginning at 10:32 AM, the Executive Director stated, "Staff who do not have CPR certification do not know who is certified for CPR. Myself, the Wellness Director and HR [Human Resources] know. There was not a CPR certified staff in the building between 10 PM and 4 AM that evening. There is no way for the uncertified staff to know which staff have CPR certification. She [Wellness Director] received the call at 5:06-5:07. EMTs were already here." When asked, "How does the staff know how to respond?" the Executive Director responded, "They don't." During an interview on 9/22/25 at 11:15 AM, Staff A, Medication Technician, stated she is trained in CPR. She has been employed with the facility for 10 years. On the day of the incident on 8/31/25, Staff A was on shift at 4 AM together with Staff B and Staff C. Staff A was assigned to the Memory Care Unit together with Staff C. Staff B needed help with Resident #1 in a different unit and called Staff A to assist. Later, Staff B called Staff A on the radio about Resident #1 again and said, "I need help". Staff A met Staff B in the lobby. Staff A said Staff B stated, "I don't think she is breathing." Staff A advised Staff B to call 911, which she did. Staff A said she was not aware of being the only person trained in CPR on that shift. She stated, "I thought everyone was trained on how to do CPR."	A 030		

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A 030	Continued From page 9 During a telephone interview conducted on 09/22/25 at 12:39 PM, Staff B, Medication Technician, stated that the first time she needed help with Resident #1, Staff A came to the resident's room to help. They gave the resident oxygen. After that, Staff B said she went away to perform her duties and came back to check on the resident later and found her unresponsive (not moving, not breathing, no pulse.) Staff B said she did not have a CPR certification at the time of the incident. She said Staff A came to Resident #1's room to check on her and advised calling 911. Staff B went out of the resident's room to call 911 and was not aware if Staff A conducted CPR. "I went and checked her blood pressure and temperature, after that I went back to the med room [medication room]. I passed out pills to two residents, and when I got back to her [Resident #1's] room, she was unresponsive. She was not moving, breathing, nothing. Yes, I checked for a pulse, and she did not have one. We are to call for coworkers and get the AED [Automated External Defibrillator] machine. That morning, I was the one calling the paramedics. My coworker [Staff H] was in Resident #1's room when I was calling. I was in the med room on the phone. When I come in for a shift, I know the names of the ones who are CPR. Our med tech [medication technician], [Staff G's name] is." During a telephone interview conducted on 9/22/2025 at 5:19 PM, Medical Doctor A (Resident #1's primary physician) stated, "I would expect the facility staff to perform CPR on any individual who was a full code status." During an interview conducted on 9/23/25 at 5:55 AM, Staff B stated on 08/31/2025, Resident #1 called with her pendant. Staff B responded to Resident #1's room and found the resident on the	A 030		

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A 030	Continued From page 10 floor on her left side. Staff B stated she called Staff A for help. Staff A and Staff C were assigned to the Memory Care Unit during that shift. After helping Resident #1 for the first incident, Staff B passed medications to 2 different residents and also helped to dress and change a resident. Staff B stated she then went back to Resident #1's room and found her unresponsive. Staff B stated that she called Staff A for help again via the radio. Staff A came and told her to call 911. Staff B went to the med tech room to call 911 (because her personal cellular phone was broken) and to check if the resident had a DNRO. Staff B said she found out the resident did not have DNRO. Staff B stated she was still in the med tech room on the phone with 911 when the paramedics arrived. Staff B went back to Resident #1's room together with the paramedics and found out CPR was not attempted. The paramedics asked why CPR was not done and pronounced Resident #1 deceased. Staff B stated the paramedics did not do CPR or use an AED. Staff B said that she was not CPR certified, but she knew who was certified. Staff B said there was another staff member [Staff H] not certified to do CPR in the room when the paramedics arrived. Staff B could not recall the staff member's name and said they no longer worked for the facility. During an interview conducted on 09/23/2025 at 6:09 AM, Staff A was asked why CPR was not started when Resident #1 was found unresponsive. Staff A responded, "I don't know. We had several residents in the Memory Care Unit who were agitated." Staff A reported she did not recall if there were any other staff members on that shift that had already left the job. Staff A said she didn't know Staff B was not certified to do CPR.	A 030		

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A 030	Continued From page 11 During an interview on 09/24/25 at 10:03 AM, the Director of Nursing (DON) stated on the morning of the incident, Staff A called her at 5:07 AM, and she sounded "stressed." The DON said that Staff A stated Resident #1 was gone, she passed away, and they didn't know why. Staff A said paramedics were already on site. The DON stated she asked Staff A what happened, and Staff A described how they helped Resident #1 after the fall, gave her oxygen, and checked her vitals. The DON said Staff A and Staff H, Medication Technician, did not check the resident's oxygen level and blood sugar, although she would have expected them to do that. The DON said the staff found the resident dead 15-20 minutes after helping her for the first time, and unfortunately Staff A froze and did not perform CPR as expected. The DON said Staff A did go into the resident's room after she was found unresponsive. The DON stated that no staff retrieved the AED. When the DON got to the facility, paramedics were already gone, and everything was quiet. She went to the resident's room, and there was a police officer there and Resident #1's body was covered up. The DON did not know how long it took between finding Resident #1 unresponsive and the arrival of the paramedics. During a telephone interview on 09/24/25 at 10:53 AM, Staff H reported she was a registered nurse without a current license or current CPR certification. On the morning of the incident, Staff H was working in memory care with Staff C. Staff A came in at 4 AM to the assisted living unit of the facility. When Resident #1 called with her pendant the first time, Staff H and Staff C were in the memory care unit. Staff A came to get Staff H to go to Resident #1's room when Resident #1 was found unresponsive. Staff H stated she went	A 030		

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A 030	Continued From page 12 to the room and Staff A stayed in memory care. Staff H reported no CPR was performed on Resident #1. Review of a written statement by Staff B, dated 08/31/25, documented it read, "Going into the morning of 08/31/25 at around 2:30 AM the resident [Resident #1] was asleep in her bed. At approximately 4:30 AM the resident pushed her pendant. I went to go check on her. opening the door to her room. The resident was lying on the floor on her left side. I called for my coworker [Staff A]. Shortly after [Staff A's name] arrived to her room asked the resident what happened, and she told us she was going to the bathroom, and her legs were shaking and gave out and she fell. We asked if she was hurting, she said no. We did range of motion and then helped her up to stand. Again, her legs were shaking. She asked if we can give her a few minutes to lay down, we changed her and told her we will be back in about 10-15 minutes to check on her. Staff A asked her if she wanted her oxygen and she said yes she gave it to her and she [Resident #1] placed the nasal cannula on. I checked her B/P [blood pressure] it was 139/71 her temp [temperature] was 97.5. I didn't get to check her O2 [oxygen]. After I went to check on her around 4:50 AM and that's when I found the resident non-responsive." Review of a written statement by Staff A, dated 8/31/25, documented it read, "[Staff B's name] called me down to [Resident #1's name] room. [Resident #1's name] was on the floor on her left side. Asked resident if she was ok. Stated to [Staff B's name] our best bet was to get [Resident #1's name] onto the bed. [Resident #1's name] stated she needed to roll over then. Resident rolled over onto back. Assisted to her feet. Resident stated she wanted to lie down. Helped	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963839	A. BUILDING: _____ B. WING _____	C 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 13 resident into bed. Asked [Staff B's name] to check back in on resident in 10-15 minutes. [Staff B's name] later yelled for help over the radio. Met [Staff B's name] in the lobby, [Staff B's name] stated she didn't think [Resident #1's name] was breathing, instructed [Staff B's name] to call 911 and I stayed in Memory Care so there would be two staff back there." Review of written statement by the DON, dated 8/31/2025 at 7:30 AM, documented it read," Who it may concern, My name is [Name of DON}, LPN (Licensed Practical Nurse), RWD (Resident Wellness Director) at the [Name of the facility]. I received a phone call at 5:07 AM on 8-31-25, From [Staff A's name] -Med tech that morning on AL [Assisted Living] side. She stated that EMS was at the building and resident [Resident #1's name] [room number] was found unresponsive in her room. [Staff A's name] stated, [Staff B's name] had checked on her around 4:30 AM, resident stated she was on her way to the bathroom, and her legs were shaky, which resulted in her fall. They did range of motion and helped her (resident) back in bed, (but her legs were a bit shaky, again.) Resident asked [Staff A's name] to come back and check on her in about 15 mins [minutes]. [Staff A's name] stated to me she went to go help other residents, and 15-20 mins later, [Staff B's name] called her to come check on resident with her and found her unresponsive. I told her I would call [Administrator's name] and I would be on my way to the building. I arrived approximately 6:37 AM and proceeded to the resident's room and spoke with the police officer-resident body was on the bed covered with a sheet. Police asked me to call resident brother and get back with him. I called the brother multiple time he did not answer, after an hour of no luck. I went back to the police	A 030		

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A 030	Continued From page 14 officer in the room and told him I could not reach the brother, he stated he will send a sheriff out to the brother home to let him know what happened. I documented and called the funeral home for transport. I left around 8:09 AM and reported to my Admin of what had happened." Review of facility policy and procedure titled, "Resident Emergency-cardiac arrest", read, "All staff must know how to react to a cardiac emergency quickly and correctly...How to make it happen... A assess the resident's condition... 2. If any of the following symptoms are present, the situation may be cardia arrest. a. no pulse b. no heartbeat c. resident is unconscious...Take the lead. 1. ask another staff member to call 911 on the telephone while you stay with the resident. 2. If no one else if available, quickly call 911 on the telephone. 3. Begin CPR only if you have been trained in CPR, and according to the resident's advance directives." Review of facility policy titled, "Healthcare Decision-making Policy," read, "1. The resident's healthcare decision-making choices are indicated on the Emergency Data Sheet as part of the pre-move-in process. 2. Copies of healthcare decision-making documents -events directives, Do Not Resuscitate Orders (DNR), Medical Powers of Attorney, and Guardianship Orders-are obtained and made part of the resident record. 3. Summarize the resident's healthcare choices on a log sheet and/or Service plan and make it available for staff members to understand and follow. 4. Send copies of healthcare decision-making documents with the resident to the receiving facility when an emergency transfer takes place. 5. Update healthcare choices, records, and documents as needed to accurately reflect the resident's/resident representative's	A 030		

Agency for Health Care Administration

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A 030	Continued From page 15 current choices. a. Update the emergency data sheet as needed." Class I	A 030		