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
	AL11922257	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA GARDENS ALF	701 WEST 9TH STREET RIVIERA BEACH, FL 33404

(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
ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

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

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on records review and interview, the facility failed to maintain an approved copy of its comprehensive emergency management plan (CEMP). The findings included: On , at around 2:00 PM, the Administrator of the facility was asked to provide evidence of its approved comprehensive emergency management plan (CEMP). The Administrator responded that she did not have a copy of the requested plan at that time and stated that it was online. The Administrator also stated that the plan was not yet approved. Review of the last approved plan revealed that it expired on . . The new plan was due to be submitted on , . . As of , the facility still did not have an approved plan. The Administrator reported on at about 4:00 PM, they were working on the CEMP and hoped it will be approved soon. Class III	ZZ830		

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A 000	Initial Comments An unannounced Relicensure and Generator Monitoring survey was conducted at Victoria Gardens ALF on - . The provider had deficiencies at the time of the visit.	A 000		
A 052	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 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.	A 052		

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A 052	Continued From page 1 (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 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.	A 052		

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A 052	Continued From page 2 (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, 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	A 052		

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A 052	Continued From page 3 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 control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 3 of 6 sampled residents (Resident #4, #5, & #6) received assistance with their self-administered medications as physician prescribed. The findings included:	A 052		

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A 052	Continued From page 4 Review of the medication observation records (MORs) on at 9:45 AM revealed no signatures for medications given the morning of between 7:00 AM and 8:00 AM. On at 9:40 AM, during inspection of the kitchen and the food storage cabinet, the Health Department representative found three plastic cups containing medications (pills) and three loose pills and brought them to the Surveyor. Review of the cups revealed the names of three individuals. An interview with Staff A on at about 9:45 AM confirmed that the three individuals were residents of the facility identified as (Residents #4, #5, & #6). Each cup contained between 8 to 11 pills. Resident #4's cup had nine pills, Resident #5's cup had eight pills, and Resident #6's cup had eleven pills. Review of the MOR on confirmed that Residents #4, #5 and #6 were respectively prescribed nine, eight, and 11 pills (photographic evidence of the MOR retained). The evidence from the MOR coincided with the number of pills found in each cup and with the prescribed medications for each resident (Resident #4, #5, & #6). Between 10:00 AM and 10:15 AM, on , interviews conducted with Residents#4, #5, and #6 confirmed they did not receive their morning medications on . Resident #4 said he usually gets his medications in the morning, and they usually wake him up to give him his medications. Resident #4, and Resident #5 said no one brought their medications to them. Review of Resident #4's health assessment	A 052		

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A 052	Continued From page 5 (AHCA form 1823) dated documented diagnoses of 's , , , , ; ; Impulsive , and . Section 2 of the form outlined Resident #4 needed assistance with self-administration of medication. Review of Resident #5's AHCA form 1823 dated documented the following diagnoses: ; Type II; ; Aneurysm. Section 2 of the form outlined Resident #5 needed assistance with self-administration of medication. Review of Resident #6's AHCA form 1823 dated documented the following diagnoses: ; ; ; in left ; , Type II; Hyperfunction of ; , historu of . Section 2 of the form outlined Resident #6 needed assistance with self-administration of medication. Multiple attempts to communicate with Staff D who worked the night shift on from 11:00 PM to 7:00 AM, and who, according to Staff C, assisted residents with self-administration of medications, were not available. Staff D cell phone was not working. The Administrator was informed of the findings on at 4:30 PM. She provided no additional information. Class III	A 052		

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A 054	Continued From page 6	A 054		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical ˘, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on the facility medication policy review, residents' records review, and interview, the facility failed to ensure that the medication observation record (MOR) was signed after	A 054		

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A 054	Continued From page 7 assisting 3 of 6 sampled residents (Residents #1, #2, & #3) with taking their medications. The findings included: Review of the facility's medication policy in assisting residents with taking their medications outlined "the appropriate staff will sign for medication at time of removing bingo cart, and appropriate staff will circle the time if the resident does not take the medications and document, it in the chart. Otherwise, the appropriate staff will enter a check or similar mark to document assistance". On at 10:25 AM, review of the MOR revealed there were no signatures in the slot, to indicate that the Residents received their medications. (photographic evidence retained). Residents #1, #2, #3 had medications prescribed to be taken at 8:00 AM, 5:00 PM, and 8:00 PM. Resident #1's medications were 500 mg (8:00 AM & 5:00 PM); Invega Trinza 410 mg/1.3 ML at 8:00 AM; 25 mg at 8:00 AM; 325 mg at 8:00 AM; D3, 125 MCG 5000 IU at 8:00 AM and Lybalvi MG at 9:00 AM. Resident #2 was prescribed 10 MG at 8:00 AM and 5:00 PM; 50 MG at 8:00 AM; 100 MG at 8:00 AM; Ceratite Senior at 8:00 AM. The medications prescribed for Residents #3 were 500 mg 8:00 AM; 500 mg at 8:00 AM; 30 MG at 8:00 AM; Sod 40 mg 8:00 AM, and	A 054		

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A 054	Continued From page 8 50 mg at 8:00 AM. At 4:30 PM, the findings were discussed with the facility's Administrator and she provided no comments. Class III	A 054		
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	A 078		

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A 078	Continued From page 9 provider indicating that the individual does not constitute a risk of transmitting a communicable . (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 observation, records review, and interview, 2 of 3 employees (Staff B & Staff C) failed to complete the annual physical	A 078		

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A 078	Continued From page 10 examniation to determine they are free from communicable ( ). The findings included: On at 9:00 AM, both Staff B and Staff C were observed at the facility working performing their assigned duties. Review of the Employees' records revealed Staff B was hired on as a home health Aide. Review of Staff B's physical record showed a health screening that was completed on . The screening indicated Staff B was free from . There no evidence provided to indicate Staff completed an annual physical exam. Staff C employment record showed a hiring date of . Staff C works at the facility as a home health Aide. Review of a health screening record documented Staff C completed a screening on . During an interview with Staff B on at about 4:02 PM, Staff B said she was scheduled to go do the screening but has done it yet. The findings were discussed with the Administrator and she said she will take care of all identified issues. Class III	A 078		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011	A 084		

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(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 084	Continued From page 11 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:	A 084		

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A 084	Continued From page 12 a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and , , rate.	A 084		

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A 084	Continued From page 13 (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that 1 of 3 sampled employees (Staff B) completed 2-hours of annual medication training update. The findings included:	A 084		

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A 084	Continued From page 14 On during employees' records review, it was noted that Staff B completed six hours of initial medication training on . Further review revealed Staff B had not completed the continuing education for medication assistance for 2025, no documentation within the file. Review of the staffing schedule documented Staff B was a current employee of the facility. In an interview with Staff B on at 4:02 PM, while assisting residents take their medications, Staff B stated she has been working at the facility for three years. Staff B acknowledged she has not completed the annual 2-hours medication training update. Staff B said that she will soon take the class. The findings were discussed with the Administrator on at 4:30 PM. The Administrator provided no additional information. Classs III	A 084		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module	A 092		

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A 092	Continued From page 15 of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to implement procedures to establish and maintain a safe and sanitary kitchen environment, as evidenced by the presence of insects (roaches). As a result of unsatisfactory food service inspections conducted on ˘ . , ˘ , and ˘ . , the Department of Health (DOH) mandated the facility to immediately cease the operation of the kitchen for all food services. In addition, the facility failed to ensure that food served in the facility met the nutritional needs for a census of 12 residents (Resident #1-#12). The finings included:	A 092		

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A 092	Continued From page 16 Review of recent DOH inspections for the facility revealed the facility has failed to maintain the kitchen in a safe manner, that jeopardized the safety and wellbeing of all residents residing at the facility. The facility failed to implement procedures to correct violations and warnings identified by DOH since , . The following events occurred at the facility resulting in the immediate order of Cease of Operations of Food Service on . I, On , a Department of Health (DOH) representative completed a routine inspection of the facility's food service areas. A review of the DOH Inspection Report dated (12:01 PM) revealed the facility received violations in the following areas. a) Supervision - Certified Manager/person in Charge present Violation comments: Observed PIC/Certified Food Manager is not present. 64E-11.003(3). A Person in Charge (PIC) is present and if applicable, presents valid documentation of being a certified food protection manager. b) Employee Health -Responding to and events Violation comments: observed Missing written procedure for the clean up of vomitting and events 64E-11.003(3). The food establishment has written procedures that address specific actions to minimize contamination and exposure of or events. c) Time/Temperature Control for Safety -Holding temperatures Violation comment: Soup is observed on the	A 092		

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A 092	Continued From page 17 kitchen counter at a temperature of 120 64E-11.003(2). PHF/TCS foods, which are held hot and not subject to an approved HACCP plan, must be maintained at 135°F. d) Food Temperature Controls-Approved thawing methods, thermometers provided and accurate Violation comments:Observed Facility using unapproved thawing method, I see ground beef inside a defrosting compartment on the kitchen counter. Shall be Use approved thawing methods. e) Prevention of Food Contamination- insects, rodents and animals not present Violation Comments: Cockroaches are observed on the kitchen counter near the microwave. 64E-11.003(5)(f). Effective measures shall be taken to control the presence of pests in the food establishment. Unless otherwise approved, live animals shall not be allowed . f) Proper Use of Utensils - Utensils: properly stored Violation comments: Dust residue is observed in the compartment where there are pots and trays. Shall be Store in-use utensil on a clean surface cleaned at an approved frequency. g) Physical facilities- facilities installed, maintained and clean Violation Comments: Observed walls with a lack of maintenance and holes next to microwave Shall be Repair and maintain all floors, walls and ceilings as needed. These violations resulted in the facility receiving an "Unsatisfactory" inspection (copy obtained). Reinspection date noted as at 8 AM.	A 092		

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A 092	Continued From page 18 On , a Department of Health (DOH) representative completed a routine inspection of the facility's food service areas. A review of the DOH Inspection Report dated (12 PM) revealed the facility received violations in the following areas. a) Supervision - Certified Manager/person in Charge present Violation comments: Observed PIC/Certified Food Manager is not present. 64E-11.003(3). A Person in Charge (PIC) is present and if applicable, presents valid documentation of being a certified food protection manager. b) Employee Health -Responding to ⌄ and events Violation comments: observed Missing written procedure for the clean up of vomitting and events 64E-11.003(3). The food establishment has written procedures that address specific actions to minimize contamination and exposure of ⌄ or events. c) Time/Temperature Control for Safety -Holding temperatures Violation comment: Soup is observed on the kitchen counter at a temperature of 120 64E-11.003(2). PHF/TCS foods, which are held hot and not subject to an approved HACCP plan, must be maintained at 135°F. d) Food Temperature Controls-Approved thawing methods, thermometers provided and accurate Violation comments:Observed Facility using unapproved thawing method, I see ground beef inside a defrosting compartment on the kitchen counter. Shall be Use approved thawing methods.	A 092		

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A 092	Continued From page 19 e) Prevention of Food Contamination- insects, rodents and animals not present Violation Comments: Cockroaches are observed on the kitchen counter near the microwave. 64E-11.003(5)(f). Effective measures shall be taken to control the presence of pests in the food establishment. Unless otherwise approved, live animals shall not be allowed . f) Proper Use of Utensils - Utensils: properly stored Violation comments: Dust residue is observed in the compartment where there are pots and trays. Shall be Store in-use utensil on a clean surface cleaned at an approved frequency. g) Physical facilities- facilities installed, maintained and clean Violation Comments: Observed walls with a lack of maintenance and holes next to microwave Shall be Repair and maintain all floors, walls and ceilings as needed. These violations resulted in the facility receiving an "Unsatisfactory" inspection (copy obtained). Reinspection date noted as at 8AM. On , a Department of Health (DOH) representative completed a routine inspection of the facility's food service areas. A review of the DOH Inspection Report dated (12 PM) revealed the facility received violations in the following areas. a) Supervision- Certified Manager/Person in charge present Violation Comments: Person in Charge (PIC) is present and if applicable, presents valid documentation of being a certified food protection	A 092		

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A 092	Continued From page 20 manager. Observed Manager not present. 64E-11.003(3). A Person in Charge (PIC) is present and if applicable, presents valid. b) Employee Health- Responding to ⌄ and events Violation Comments: The food establishment does not have a written procedure of ⌄ and . Observed the food establishment does not have a written procedure of ⌄ and . c) Food Temperature Control- Thermometers provided and accurate Violation Comments: Observed that no thermometer inside the refrigerator d) Prevention of Food Contamination- insects, rodents, and animals not present Violation Comments: Eight live cockroaches observed in a cockroach trap inside cabinet next to cooking pans.Observed multiple cockroaches in cabinets. One in cabinet above microwave, one in cabinet next to reach in freezer, one in drawer with oven mitts, one in right side cabinet with cooking pans, and one on food prep counter. e) Physical facilities- facilities installed, maintained and clean Violation Comments: Holes in the wall behind food prep counter on microwave wall. Walls shall be in good repair. On , a " delivered" Emergency Suspension of Food Sanitation Certificate and Order to Cease Operating All Food Service at	A 092		

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A 092	Continued From page 21	A 092		

Facility was issued to the facility by the DOH Representatives to notify them that the Food Sanitation Certificate was temporarily suspended. The letter documented the following:

"The Department inspected your facility on the following dates: [redacted] and [redacted], and found evidence of a substantial cockroach infestation including numerous live and roaches. Despite issued warnings on [redacted] and [redacted], the problem has persisted and has affected food service areas. Inspectors observed eight living roaches, four roaches in cabinets, as well as, a roach on the food preparation counter. The Department finds that there is an immediate serious danger to the public health, safety and welfare of your residents which requires immediate temporary suspension of your Sanitation Certificate and immediate cessation of the operation of your kitchen for any food services. You must cease operating the kitchen and provide your residents with meals through alternative means. The Department's action is warranted under the circumstances as it is the only way at present to ensure that the cockroaches do not contaminate the food products being supplied to your residents." (copy obtained).

On , upon arrival to the facility at approximately 11:45 AM, it was observed that facility staff (Staff C and D) were serving the resident's ramen noodles and a sandwich. At this time, the AHCA surveyors intervened and immediately stopped the Staff from serving any further food. Staff were observed using the kitchen, food items and utensils from the kitchen. Staff stated that she was aware of the kitchen closure, however, the Administrator hadn't made

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A 092	Continued From page 22 alternative arrangements or informed the staff how to proceed due to the closure of the kitchen as sanctioned by DOH. Staff also confirmed that the kitchen had been used the prior evening also to prepare and serve meals to the residents. The Administrator was not present at this time, she was contacted by phone at 11:54 AM and 12:14 PM and asked to return to the facility based on the findings on and to provide a lunch alternative. She stated that she would bring pizza. The Administrator arrived at 12:57 PM, with 4 boxes of pizza (medium size), no additional food items to meet the daily dietary requirements per meal. During an interview with the Administrator on at approximately 12:57 PM (upon her arrival), she confirmed that she was served the Emergency Suspension order on ˘ , ˘ . She was asked why was the kitchen and products from the kitchen used to prepare and serve to residents and the order violated. She stated, "I didn't have time to prepare". She was ordered immediately to cease further operation and use of the kitchen and to follow the Emergency order from DOH. At this time, the Administrator was informed that she needed to establish a meal plan for the residents that included the meals to be served for current day and the following day, and the provider (Caterer) of the meals and how she planned to safely ensure delivery of meals until the kitchen is authorized to reopen. She was informed that she must notify the Agency daily via email, and to include the temperature readings of all meals. Upon arrival of the DOH Representative around 12: 55 PM, the Administrator was reminded of the cease order that she received the prior day (˘ ˘). She was informed that she was not allowed to use the kitchen for any services.	A 092		

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A 092	Continued From page 23 Although, the Administrator was notified of the Emergency Suspension/Cease Order for the kitchen on around 4:30 PM, she failed to establish an alternative meal plan procedures for staff and the residents. The Administrator implemented a plan only after surveyor intervention on after 12 PM. Prior to this visit, the Administrator failed to contact their licensed Dietician to discuss meal options for the 12 residents residing at the facility. II. On at 9:00 AM, upon arriving at the facility, a new shipment of food was observed being delivered to the facility. At 9:40 AM, during the tour of the kitchen area and food storage area, the Surveyor observed and noted multiple food storage issues: a) There was a quarter of gallon of milk found in the refrigerator with a 'best by date' of . According to the Food and Drug Administration (FDA), the best by date "indicates when a product will be of best flavor or quality". They recommend using senses (taste, smell, visual) to determine whether the item should be discarded. Observation of the gallon containing the milk showed it was bulging and gaseous, the milk was spoiled. b) There was about a quarter of a gallon containing tartar sauce with no opened date. c) There was leftover noodle soup found in the refrigerator with no label or date. d) There was leftover green beans casserole which appeared spoiled in an undated container. e) Leftover tuna salad with mayonnaise was found in the refrigerator with no date and label. f) Multiple roaches (and alive) were found in the kitchen cabinets by DOH.	A 092		

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A 092	Continued From page 24 During an interview with Staff A(Administrator) and B (Caregiver) on at about 9:45 AM, they could not say why those leftover foods were placed in the refrigerator, and how long they have been there. 2) At about 10:00 AM on , interviews conducted with Residents #1, #2, #4, and #5 revealed the breakfast menu was not followed. The residents said the morning of , they were served cereal with milk and or coffee. Review of the menu for documented breakfast "Assorted juices, English muffins or bagel, Turkey sausage, Margarine, Cream Cheese, and Milk. According to the residents no turkey sausage was served. Staff C (Caregiver) said, during an interview on at about 10:00 AM, she was present during breakfast but she did not know whether the Residents received the items listed in the menu. She said the Staff who worked the overnight shift served breakfast at 8:00 AM, before she left her. Review of the Department of Health (DOH)'s Emergency Suspension of Food Sanitation Certificate and Order to Cease operating all food service at the facility dated , revealed the facility had failed to correct warnings issued during inspections of the facility's kitchen conducted on and due to evidence of substantial cockroach infestation in the food service area. Many cockroaches (and alive) were observed in the food service area and in the kitchen cabinets. Furthermore, despite the Cease Order issued on by DOH, during reinspection visits to the facility by two other Surveyors on and , the	A 092		

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(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 092	Continued From page 25 facility was found to be in violation of the DOH's order to temporarily discontinue using their kitchen (including all items in the kitchen area). The issues were discussed and reviewed with the Administrator on at 4:30 PM and on , she stated they will address all the concerns. Class II	A 092		
A 152	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 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	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922257	A. BUILDING: _____ B. WING _____	08/25/2025

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A 152	Continued From page 26 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 observations and interviews, the facility failed to provide a clean environment that was homelike for 12 of 12 residents residing at the facility. The findings included: During a tour of the facility on at 10:00 AM, the following issues were observed: a) near the South end of the building on the right had an unbearable odor. There was a resident sleeping on his bed and another bed frame with wire springs was exposed on the other side of the wall. b) The South exit door was covered with black with scuff marks and greasy-like materials. c) The garbage observed in the dining room was left uncovered with debris exposed. d) Multiple doors were observed with no locks for privacy (, & 6). e) In , it was noted that the air conditioning wall unit air filter and vent were filmed with dust. f) The air-recycling fan cover, in the bathroom	A 152		

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
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A 152	Continued From page 27 near , was hanging at the ceiling and was covered with dust. g) The central air conditionning condenser was leaking water on the floor. The air filter was unrecognizable with dust covering its entire surface. The air could no longer filter the air and was partially sucked in the air conditi. h) many live and roaches were observed in the damped area of the central AC condenser. i) There was a large sheetrock hapzardly placed against the wall in the hallway near the bathroom adjacent to . At 10:25 AM health department agent finds three plastic cups containing pills that were not given to the residents. The findings were discussed with the Administrator on at 4:30 PM, no additional information was provided.	A 152		