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
	AL11969198	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF OAKLEAF	417 OAKLEAF PLANTATION PKWY JACKSONVILLE, FL 32222

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A 000	Initial Comments A complaint survey, complaint #2025015186, was conducted at The Addison of Oakleaf on through . 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, , , or to a resident receiving care in a facility. The facility failed to honor a Do Not Resusciate Order by initiating on an unresponsive resident who did not want such measures to be taken. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 1:54pm. 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( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES.	A 030		

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A 030	Continued From page 1 (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; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and	A 030		

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A 030	Continued From page 2 , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and	A 030		

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A 030	Continued From page 3 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 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.	A 030		

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A 030	Continued From page 4 (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the	A 030		

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A 030	Continued From page 5 residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever	A 030		

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A 030	Continued From page 6 possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of 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 interview and record review, the facility failed to honor the advanced directive to have , , ( ) withheld if found unresponsive, for 1 of 4 residents with an active ( ) who was found unresponsive (Resident #1). Failing to create a system that honors properly executed advanced directives has the potential to negatively effect all 30 current residents with . The findings include: Record review revealed that Resident #1 was admitted into the facility on with diagnoses that included , , and , . Among Resident #1's admissions documents was the Florida Department of Health (DOH) Form DH 1896 signed by the resident's authorized representative and a health care provider on . Photographic evidence obtained.	A 030		

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A 030	Continued From page 7 A progress note dated at 8:32am documented the following events: Resident #1 sitting in the dining room and was heard making a loud noise. Care staff found she wasn't breathing, so they laid her down and initiated until they were able to confirm she had a . Emergency services and the fire department arrived. Her time of was 8:32am. The note was created by the Wellness Director (WD). Photographic evidence obtained. Review of a record provided by the WD revealed a list of 30 current residents with a . Photographic evidence obtained. An interview was conducted on at 11:15am with Resident #6. Resident #6 stated that she did not "want any heroic measures done" to preserve her life. When was mentioned she commented, "I hope they [the facility staff] would not do that." A yellow form was observed in the room behind the door. An interview was conducted on at 11:51am with Resident #8. She confirmed that she had a . She stated she believed this would be honored if she were to become unresponsive. No yellow form was observed in the room. (Resident #8 stated in an interview at 10:59am on that the yellow form was posted behind her door about 2 hours after this interview on . Observations during this time conformed the form was now affixed to the door.) An interview was conducted on at 12:02pm with Resident #9. The resident confirmed that she had a . Resident #9 stated that she did not wish to be if	A 030		

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she were to be found unresponsive and believed they would respect that wish if she were found unresponsive. A yellow form was observed in the room behind the door.

An interview was conducted on at 12:23pm with Resident #10. He confirmed that he had a . He stated that he did not want to be if he were to be found unresponsive. A yellow form was observed in the room behind the door.

An interview was conducted on at 12:27pm with Resident #11. She confirmed that she had a and stated that she would not want to be if she were to be found unresponsive. A yellow form was observed in the room behind the door.

An interview was conducted on at 12:36pm with Resident #12. She confirmed she has a and stated she did not want to be if she were to be found unresponsive and that she thought staff would honor this if found unresponsive. A yellow form was observed in the room behind the door.

An interview was conducted on at 12:53pm with Employee A, Resident Aide ( ). She stated that she had received training on Resident Rights and the facility's policies and procedures. She was present on . When she was called to Resident #1's table in the dining room, she heard her making a "strange noise" and called for help. Employee B came to assist her. While Employee B was with Resident #1, Employee A went to call 911 and the WD. Employee A explained that when she returned to the dining room, Resident #1 had been moved to the floor and that Employee B was performing

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A 030	Continued From page 9 . Employee A confirmed she didn't verify Resident #1's code status during this time. She stated the form is typically provided when the paramedics arrive. Employee A was asked how residents with were identified. She answered the paper form was behind the door, and the information is in their computer system. She was asked whose responsibility it was to ensure the forms were available. She replied, "It's up to the nurses to make sure they have the forms." An interview was conducted on at 1:21pm with Employee F, . She stated she had received training on Resident Rights and the facility's policies and procedures, and confirmed she had certification. She stated that the are typically posted on the of the resident's room door and the information was also located at the front desk. If she found a resident unresponsive, she would stay with the resident and ask another staff person to go to the room and report the code status to her. She stated she would start until she confirmed that the resident had a , then discontinue . Employee F explained this was the facility's procedure: Start while you're waiting to verify the . An interview was conducted on at 2:30pm with Employee B, a Med Tech who confirmed she assisted during the incident on involving Resident #1. She described the events as follows: After she received a call for assistance from Employee A, she reported to the area and found Resident #1 unresponsive. She referred to the resident as " ," "blue," and she "didn't have a ." Resident #1 was not responding to the sternal rub that she was performing. She instructed Employee A to verify if	A 030		

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the resident was a and to call 911. When the WD arrived she instructed her to stop and advised them that the resident had a . She confirmed that she stopped the , at that time.

Employee B was asked if she had received any recent training regarding the facility's policy. She responded she "didn't really have training" from the facility, "I'm in nursing school." She was asked what was the facility's policy regarding performing on someone with a . She responded, "I was told that the policy is to start , until [Emergency Medical Services] gets there." She was then asked who had advised her of this, and she said it was the WD, after the incident with Resident #1. Employee B stated she could identify a resident's code status by looking in their chart, on the of their doors, or on their facility-issued phones.

An interview was conducted on at 3:23pm with the WD. She stated that the facility did not conduct an investigation into the incident on involving Resident #1 nor was there any staff education initiated after the incident. She referred to the incident as, "pretty cut and dry." She became aware of the incident when Employee A called her on the morning of , and Employee A advised her that Resident #1 was found unresponsive. She was in the parking lot of the facility when she received the call. When she entered the facility she observed Employee B performing on Resident #1. She advised Employee B to stop as the resident had a . She stated that she had confirmed this prior to reporting to the area where the incident had occurred. When a resident was found unresponsive, staff were to call 911 and check the resident's code status,

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then notify the family, and her. She confirmed the expectation of staff to "start , until it's confirmed that it's a ," adding, "They start the , until another person tells them that the resident has a ." She was asked what was the process if a resident with a was from the during the process of verifying their code status. She responded, "If a resident is getting and becomes responsive while the code status is being verified, we still call ." She added, "If they're revived, you stop ." She stated that the facility would report the incident, but when asked what would it be reported as, she stated that she did not know and would have to consult with the facility's regional office on the matter.

At the time of the interview, the WD produced education that was provided to care staff on , two days before Resident #1 ,

Record review revealed this "All Staff" meeting was conducted on at 2:00pm. Photographic evidence obtained. The WD provided education on / . The attendance roster listed 18 staff members. Educational material included a policy review of Advanced Directives.

The policy explained the following regarding a : "A ( ) order is a written instruction from a physician or other authorized healthcare provider stating that a patient should not be given , ( ) if their stops or they stop breathing. 's are usually followed in hospitals and nursing facilities. Things are more complicated if person stops breathing while in their home, a school, or in the community."

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A 030	Continued From page 12 An interview was conducted on at 4:15pm with the Administrator. Upon hearing about Resident #1 on , he went to her area. was there, and Resident #1 was covered in a blanket. He was asked to explain the facility's expectations when a resident became unresponsive, to which he replied he had always been told that if you didn't know the code status, you initiate . He said one of two things should happen, "Either they go and verify or call the nurse and the nurse can go through the record." He acknowledged that if a resident with a received and was , "that could get you in a lot of trouble." He continued, "I don't think we need to do on anybody who has a ." He acknowledged his need to review the regulations. He also referenced the facility-issued phones, which care staff are supposed to have access to, and the ability to look in the phone for the code status before they start . On at 9:30am, Employee F explained care staff are provided facility phones which they carry during their shifts. On at 10:15am, Employee C displayed her facility issued phone which she had in her pocket. It showed all the residents on her assignment. After clicking on a resident, the code status displayed. An interview was conducted on at 11:05am with Resident #16. Resident #16 confirmed that she had a . She stated that she did not want performed if she were found unresponsive, and hoped the facility would honor this. A yellow form was observed in the room behind the door..	A 030		

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A 030	Continued From page 13 An interview was conducted on at 11:09am with Resident #14. She confirmed that she had a . Resident #14 stated that she did not want performed if she was found unresponsive and felt the facility would honor this. A yellow form was observed in the room behind the door. An interview was conducted on at 1:07pm with the WD. She stated that it was the responsibility of the Clinical Coordinator and herself to ensure that resident code status was in sync in all areas and that the yellow DOH Form DH 1896 was present. She stated that routine audits and weekly checks were to be performed, but that she had not done any audits or weekly checks since being hired in , . She stated that audits of the books as well as observation of the residents' doors to confirm presence of the yellow forms should have been conducted, and confirmed that she had not done this. She stated that if there was a [ ] form staff need to locate it; the code status was listed on the resident's sheet and that the form should be located in the resident's electronic record. She repeated that staff are to perform "until they have the actual form." She added, "They shouldn't just verify the sheet. They need to see the actual form." During an interview with the Administrator on at 1:54pm, he stated that he was informed that "AHCA had changed the policy on " and " was not to be performed on any resident with a ." He stated that this conflicted with the Department of Health, which stated something different, but details were not provided.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969198	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF OAKLEAF	417 OAKLEAF PLANTATION PKWY JACKSONVILLE, FL 32222

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A 030	Continued From page 14 Attachment H 7 of 11 Residence and Service Agreement - Assisted Living titled: ADVANCED DIRECTIVES AND POLICY AND PROCEDURE revealed: "4. The Community staff trained in (manually or via an) will handle as follows: Resident on hospice - the Community staff will contact hospice immediately and follow hospice procedures. Resident not on hospice - the Community staff may withdraw or withhold as well as call 911. Please note: depending on the location of Resident at the time they are observed to be in or , , , staff trained in may initiate on Resident with a until such time it is determined that a legally executed order exists. At that time, will be withdrawn." Photographic evidence obtained. CLASS I	A 030		