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
	AL11964586	A. BUILDING: _____ B. WING _____	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEHIGH ACRES PLACE	1251 BUSINESS WAY LEHIGH ACRES, FL 33936

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A 000	Initial Comments A relicensure, emergency power plan monitoring, health facility reporting system survey and complaint investigation for #2025014132 was conducted at Lehigh Acres Place on . . . . through . Deficiencies were identified at the time of survey. .	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032		

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A 032	Continued From page 1 at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent elopement for 2 (Residents #4 and #7) of 3 residents at risk for elopement. The facility failed to ensure residents deemed at risk for elopement have identification	A 032		

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A 032	Continued From page 2	A 032		

on their person to include their name, the facility name, address and telephone number for 2 (Residents #4 and #9) of 3 residents reviewed for elopement.

The findings included:

CL12 Elopements. Policy date .
Policy: Elopement precautions will be carried out for residents who have demonstrated previous attempts to or have a history of elopement...
Procedure:
3. Residents will be provided with Community business or address cards to keep in their purses or wallets.

Review of Resident #7's Health Assessment Form (1823) dated revealed the resident was an elopement risk.

Review of progress note dated at 2:48 p.m., revealed Resident #7 was last seen having dinner in the sitting room. At 8:39 p.m., staff were notified Resident #7 was across the street at the bowling alley. Writer located resident with EMTs (emergency medical technician) and police; Resident #7 was and stated she parked her car at the bowling alley, and it was stolen. Resident #7 was moved to a memory care facility.

Review of Resident #4's health assessment dated revealed the resident was not an elopement risk.
Review of progress note dated at 8:33 p.m. revealed Resident #4 was and exit seeking but now she's to her usual routine.
Review of progress note date at 2:51

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A 032	Continued From page 3	A 032		

p.m. indicated; "late entry for . Resident was observed by oncoming staff sitting on her walker near the bank down the street. She was escorted home by staff. Front door secured and frequent safety checks provided."

Review of the facility Elopement Risk Book in the nurse's station revealed Residents #4 and #9 were at risk for elopement. (Resident #7 was discharged.)

On at 5:57 p.m., during an interview, Staff E said Resident #7 finished dinner and then the staff locked the front door. Staff E said someone unlocked the door and let Resident #7 out of the facility unsupervised. Staff E said a family member came into the facility and Resident #7 walked out when the door was opened. Staff E said Resident #7 was not allowed to sit outside by herself, and she is no longer a resident at the facility.

On at 3:17 p.m., during an interview, the Executive Director (ED) said she was present at the facility when Resident #4 eloped. The ED said Resident #4 was sitting on the front porch with another resident and when staff made rounds, Resident #4 was gone and they could not find the resident. The ED said Staff E was driving to the facility and saw Resident #4 at the bank across the street. Staff E drove Resident #4 to the facility. The ED said Resident #4 did not sign out before leaving the facility grounds, which is required by residents. The ED said current residents at risk for elopement include Resident #4 and #9. The ED said the residents have her business card on their person in case they are separated from the facility.

On at 3:27 p.m., during an observation

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A 032	Continued From page 4 and interview with the ED and Resident #4 near the lobby, Resident #4 did not have identification on her person including the resident's name, the facility name, address or telephone number. There were no identification on the ankles or . On at 3:34 p.m., Staff E said she was never instructed to check identification for Residents #4 and #9. Staff E said they are elopement risks. On at 3:56 p.m., Resident #9 was observed in her apartment. The ED checked Resident #9 for the required identification and there was none. Resident #9 was in possession of an expired driver's license. There were no identification on the ankles or . Class III .	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication	A 052		

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A 052	Continued From page 5 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. (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	A 052		

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A 052	Continued From page 6	A 052		

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.
(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

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A 052	Continued From page 7	A 052		

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 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

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A 052	Continued From page 8 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 observation, interview, and record review, the facility failed to ensure staff who assist with self-administration do so accordingly to include to orally advise of the names and doses of their medications for 4 (Residents #3, #8, #10, #11) of 4 residents observed. The facility failed to ensure staff observed residents taking their medication for 1(Resident #11) of 4 residents observed for assistance with medication self-administration, The findings included: On at 11:31 a.m., observation of Medication Technician Staff D assist with self-administration of medication for Resident #8. Staff D prepared , , , , , , D, and . Staff D placed the medication in the plastic cup with applesauce and told the resident, "Here you go nurse." Staff D did the same with the , which was mixed with water in a separate cup, stating, "Here you go nurse." Staff D did not orally advise Resident #8 of the names and doses of the medications given. On at 4:48 p.m., observation of Medication Technician Staff E assist with self-administration of medications for Resident	A 052		

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A	Continued From page 9 #3. Staff E placed the medication in the cup and handed it to Resident #3 stating it was . Staff E did not orally advise Resident #3 of the dosage of the medication given. On at 4:51 p.m., observation of Staff E assist with self-administration of medication for Resident #10. Staff E placed the medication in the cup and gave it to Resident #10 stating it was . . Staff E did not orally advise Resident #10 of the dose of the medication given. On at 5:02 p.m., observation of Staff E assist with self administration of medications for Resident #11, who was sitting in the dining room. Staff E put the medications in the cup and placed the cup in front of Resident #11. The resident did not take the medication. Staff E walked to the kitchen window and started serving dinner to other residents. On at 5:33 p.m., Resident #11 took the medication while at the dining table. Staff E was standing at the kitchen window, approximately 25 away from Resident #11 with her to Resident #11. Staff E did not observe Resident #11 taking the medication. On at 5:51 p.m., during an interview, Staff E confirmed she did not orally advise Residents #3 and #10 of their medication doses given. Staff E confirmed she did not orally advise Resident #11 of the medication names or doses given, and did not observe Resident #11 taking the medications while at the dining table. On at 9:43 a.m., the Executive Director said the facility does not have a waiver excusing staff from orally advising residents of medication names and doses. The ED said Staff D and E should have advised the residents of the	A 052		

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A 052	Continued From page 10 medication names and doses. The Executive Director said Staff E should have observed Resident #11 take the medication. Class III .	A 052		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff receive at least one hour of training in the facility's policies and procedures regarding ( ) for 2 (Staff E, F) of 4 records reviewed . The findings included: Review of the facility employee list revealed Staff E had a hire date of . Staff F had a hire date of .	A 090		

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A 090	Continued From page 11 Review of Staff E's Relias Transcript printed on at 4:27 p.m., did not include completion of 1 hour of training in the facility's policy and procedures regarding . Review of the training certificates provided by the facility did not include completion of 1 hour of training in the facility's policies and procedures regarding . Review of Staff F's Relias Transcript printed on at 4:28 p.m., did not include completion of 1 hour of training in the facility's policy and procedures regarding . Review of the training certificates provided by the facility did not include completion or 1 hour of training in the facility's policies and procedures regarding . On at 1:54 p.m., during an interview, the Executive Director said she thought the training was included in the pre-service orientation. The Executive Director said she does not train new employees. Class III .	A 090		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary	A 093		

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A 093	Continued From page 12 Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.	A 093		

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A 093	Continued From page 13 (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A	A 093		

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	AL11964586	A. BUILDING: _____ B. WING _____	10/21/2025

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A 093	Continued From page 14	A 093		

supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on .
(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure menus were dated and planned at least 1 week in advance and were conspicuously posted or easily available to residents. The facility failed to ensure food preferences were honored for 1(Resident #6) of 6 residents interviewed for food services.

The findings included:

On Monday, at 9:30 a.m., observation of the daily menu posted in the lobby. The menu was dated Sunday, . Lunch choice listed was meatball sub. In the corner of the dining room, there were 2 weekly menus in picture frames hanging over a small dining table. The menus were labeled for week 1 and week 4.

On at 12:00 p.m., the daily menu hanging in the lobby was still outdated and was labeled .

On at 12:22 p.m., observed residents in

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A 093	Continued From page 15	A 093		

the dining room eating tuna fish sandwiches and chopped fruit. Resident #5 said they were supposed to have casserole but ran out of the ingredients. One resident was observed eating hamburger on a .

On at 5:12 p.m., during an interview, Caregiver, Staff F said daily menus are given to residents and they circle what they want to eat for that day.

On at 5:26 p.m., during an interview, Staff G (Cook) said the dinner tonight is fried rice and mushroom soup.

On at 5:33 p.m. Resident #6 asked Staff E for a bowl of mushroom soup.

On at 5:38 p.m., Staff E told Resident #6 he did not order soup, and they ran out.

On at 5:41p.m., during an interview Staff E said she could not find the meal ticket for Resident #6 with the items the resident circles for the meals for the day.

On at 5:43 p.m., during an interview, the Executive Director said staff should serve Resident #6 soup if the resident asked for soup.

On at 5:45 p.m., during an interview, the Executive Director said they could not find Resident #6's meal ticket, and they were not sure if the resident circled it or not. The ED said they ran out of the soup, but they would open a new can and give the resident the soup he wanted.

On at 10:25 a.m., during an interview, Staff H (Cook) said she was off yesterday. Staff G should have changed the daily menu. Staff H said

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A 093	Continued From page 16 the weekly menus hanging in the dining room were incorrect and they are currently serving from the menu for week 3. Class III .	A 093		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable.	A 162		

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A 162	Continued From page 17 (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for Optional State	A 162		

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A 162	Continued From page 18 Supplementation ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services	A 162		

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A 162	Continued From page 19 license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure and maintain documentation of interdisciplinary care plans in the resident's records for 2 (Residents #1, #8) of 3 residents reviewed receiving hospice services. The findings included: Facility policy CL06 - Hospice. Policy date . Procedure: 2. Services being provided by the hospice agency will be addressed in the resident's service plan through a written hospice care plan. a. The hospice care plan will identify the primary hospice caregiver, alternative care givers and outline specific tasks the community is responsible for. b. The Director of Health and Wellness will review the hospice plan to ensure all care interventions are appropriate and consistent with the resident's service plan. Review of Resident #1's record revealed an admission date of . Review for Resident #1 revealed a Resident Health Assessment (1823) dated indicating Resident #1 required hospice services. Review of Resident's #1's record in the nurse's station revealed Vitas Hospice Services for Resident #1 and staff should contact hospice before any changes to the care plan. Further Review of Resident #1's record revealed no documentation of a hospice interdisciplinary care plan indicating which services would be provided by hospice.	A 162		

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A 162	Continued From page 20 On at approximately 10:30 a.m., the hospice Caregiver was observed to entering Resident #1's apartment to give the resident a shower. On at 1:17 p.m., during an interview, the Executive Director said Resident #1 did not have a hospice interdisciplinary care plan in their records. Review of the record for Resident #8 revealed an admission date of . Review for Resident #8 revealed a Resident Health Assessment Form (1823) date indicating Resident #8 required Hospice Services. Review of Resident #8's record revealed documentation of initial certification notes indicating hospice services were started on . Further review revealed an Outside Agency Documentation Form indicating recertification for Vitas Healthcare dated , Resident #8's record did not contain documentation of a hospice interdisciplinary care plan indicating which services would be provided by hospice. On at 1:17 p.m. the Executive Director confirmed there were no evidence of documentation of hospice interdisciplinary care plans in the records for Residents #1 and #8. Class III .	A 162		

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

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

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

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to $50 per day late not to exceed $500.
(b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission.
(c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to submit electronically an adverse incident report to the Agency within 1 business day after the occurrence of the incident and within 15 calendar days after the occurrence of the incident for 1 resident (#4) of 2 residents reviewed for adverse incidents.

The findings included:

Review of the facility policy: DP04 - Incident Reports. Policy Date . Procedure; 6. "The Community will furnish to the licensing agency within one (1) business day such reports as the Department may require including but not limited to:
a. Adverse incidents are submitted within one (1) business day via the licensing department's online portal.
i. Full reports are to be submitted via the licensing online portal within fifteen (15) business days of the incident."

Review of Resident #4's progress note dated at 8:33 p.m., "...Resident was at first and exit seeking but now she's to her usual routine..."

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ZZ821	Continued From page 4 Progress note dated at 2:51 p.m., "Late entry for . Resident was observed by oncoming staff sitting on her walker near the bank down the street. She was escorted home by staff. Front door secured and frequent safey checks provided..." On at 3:06 p.m., Care Giver Staff I said there is an elopement book for residents at risk for eloping. Staff I said she was here on around 1:45 p.m. when Resident #4 eloped and walked down at Suncoast Bank. She said she was doing rounds and could not find Resident #4. On at 3:17 p.m., the Executive Director said she was at the facility on at the end of the day shift, when Resident #4 eloped. She said Resident #4 walked down to the bank and did not sign out. When day shift staff were conducting rounds, they could not find Resident #4. The Executive Director said the adverse incident report was not submitted within the required time frames. Class III .	ZZ821		
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,	ZZ830		

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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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964586	A. BUILDING: _____ B. WING _____	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEHIGH ACRES PLACE	1251 BUSINESS WAY LEHIGH ACRES, FL 33936

(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	Continued From page 6 (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 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 interview and record review the facility failed to submit annually a Comprehensive Emergency Management Plan (CEMP) to the Lee County Emergency Management Coordinator as required.	ZZ830		

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ZZ830	Continued From page 7 The findings included: On , review of the facility records revealed a letter from the Lee County Emergency Management Coordinator dated . The letter referred to the CEMP submitted by the facility on . The letter stated the plan submitted did not meet the criteria set forth by the Agency for Health Care Administration and could not be approved. The letter instructed the facility to submit a correct plan within 30 days. The letter contained a telephone number the facility could call if they had any questions. On at 2:00 p.m., during an interview with the Executive Director, she said she did not have an approved CEMP. She said she realizes the CEMP is not approved. She said the last communication she had with the Lee County Emergency Management Coordinator was . Class III	ZZ830		