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
	AL11968539	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTRAM LAKES ASSISTED LIVING	6209 BROOKS BARTRAM DR BLDG 200 JACKSONVILLE, FL 32258

(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 000	Initial Comments An abbreviated relicensure survey with extended congregate care (ECC) monitoring was conducted at Bartram Lakes Assisted Living on . Deficiencies were identified at the time of survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure one of six sampled residents met continuing residency criteria, Resident #10, who relied on facility staff to utilize a to meet care needs. Findings Included: During an interview with Staff A, LPN, at 12:36pm on , she revealed Resident #10 was completely dependent for assistance with transferring, and that he required a Hoyer to aide in the transferring. She said that the resident was receiving hospice services and that the hospice provider suggested and supplied the , for staff to use for Resident #10's needs. The Hoyer was mainly used for transferring him from his high wheel chair to the his bed, and vice versa. She stated that the facility staff were trained on how to use Resident #10's , by one of the hospice care team members. They had an in-service training session on . She stated that Resident #10 had a 24-hour private duty caregiver and that 2 of the facility staff would use the , to move the resident up off his high-backed wheel chair to his bed so that the private duty caregiver could provide personal care to the resident in a reclined position. An observation of Resident #10, in his apartment, at 12:50pm on , revealed the resident lying in a reclined position, in his high wheelchair, with his private duty caregiver sitting nearby on a sofa. His , was observed stored in his apartment bathroom. He had his	A 010		

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A 010	Continued From page 5 Hoyer hammock sling tucked underneath him. Staff A was present at the observation and confirmed that the and hammock sling were for Resident #10's use. A review of Resident #10's record revealed that he was admitted to the facility on . The record showed that a hydraulic lift was ordered for the resident on , by his hospice provider. His interdisciplinary care plan (IDCP), dated , stated he was fully dependent for 5 of 6 activities of daily living (ADLs), only requiring minimal assistance with feeding. The IDCP stated the the resident would utilize a with assistance provided by 2 facility staff assistants. A record of a training session, provided to facility staff from a hospice care staff member, on , was titled Hoyer Training In-Service. 9 facility staff members signed the sign-in log for the training, including Staff A. The notes from a to encounter between the hospice nurse practitioner, Resident #10, and 2 facility care staff members, on , revealed discussing that Resident #10 had a significant decline and could no longer bear and required a for transfers. In an interview with the Administrator at 2:30pm on , he provided Resident #10's requested records and stated the facility's latest service/care plan for the resident was dated and that he was not aware of any service/care plans, by the facility or by hospice, that addressed the use and safety of using the . Photographic evidence obtained. Class III	A 010		

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A 032	Continued From page 6	A 032		
A 032	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 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	A 032		

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A 032	Continued From page 7 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 record review and interview, the facility failed ensure two of three sampled staff participated in two elopement drills per year (Staff C and D). Findings Included: Review of the facility's elopement drill log revealed two elopement drills were conducted in the past year. One on with 8 participants and one on with 8 participants. A review of Staff D's records revealed she began employment with the facility on . She was	A 032		

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A 032	Continued From page 8 not recorded as having participated in either of the 2 elopement drills conducted at the facility within the past year. A review of Staff C's records revealed she began employment on . She was only recorded as having participated in 1 elopement drill within the past year, on . In an interview with the Administrator at 4:20pm on , he stated he was not aware of the requirement for each employee to participate in 2 elopement drills per year. Class III	A 032		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented	A 055		

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A 055	Continued From page 9	A 055		

by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and,
4. Kept separately from the medications of other residents and properly closed or sealed.
(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued

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A 055	Continued From page 10 medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to properly store and secure centrally stored medications in three of three units observed. Findings Included: A tour of the facility was conducted on 11/4/25 at 9:30am. A medication cart was observed directly in front of an empty nurses station on the first floor. The medication cart was left unlocked, the lock button was not pushed in. The cart had an	A 055		

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A 055	Continued From page 11 open laptop computer, glasses, and other items on top. There were no staff members in the area or observed anywhere on the floor. The unlocked medication cart sat unlocked until 9:40am, when Staff E came to the cart and then pushed the lock button, locking the cart. During the 10 minutes that the unlocked cart was observed, several people, including employees and residents were walking around the vicinity near the medication cart. The 300 building memory care unit was toured at 12:05pm on . Upon arrival inside the unit, a small white cup containing 3 pills was observed sitting on the large open counter between the dining area, kitchen, and sitting room. A medication cart was observed next to the area where the cup of pills was left unattended. No staff member was observed manning the medication cart. There were staff members seen assisting residents with lunch, and several residents were in the area. It wasn't until 12:15pm when Staff A came to the medication cart and stated she was about to resume medication pass duties. She then stated she was finished with the medication pass in the 300 building and was going to move over to the 400 building memory care unit to conduct medication pass duties over there. She was then asked about the cup of medications still sitting on the counter in the little white cup. Staff A then apologized and stated she forgot, those medications were for Resident #1 and she had gotten called away on another task and forgot to give him his medications. She then gave Resident #1 the medications in the cup that had been left on the counter. Moving over to the 400 building memory care unit, Staff A was observed preparing to conduct	A 055		

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A 055	Continued From page 12 medication pass duties. At 12:25pm on , when Staff A opened up the medication cart to retrieve Resident #2's medications, and upon opening a drawer to locate the resident's medications, a small white cup of pre-poured pills was seen sitting in the drawer. There was no indication to whom the pills belonged or what medications the pills were. Staff A picked up the cup of pills and said they were left there from the previous shift. When asked if that was normal, she stated "no" and then said she was going to "waste" the leftover pills. She was then observed putting the pills into a container she called a "Kill Pill" container. The concerns were addressed an interview with the Administrator at 4:20pm on , but he did not comment on the observations. Class III	A 055		