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
	AL11968608	A. BUILDING: _____ B. WING _____	R 11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 A revisit survey was conducted at Seasons Gardens Senior Residences from through . Deficiencies were identified at the time of the survey. A Class I deficiency was found at Tag A0025, A0079. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is neccessary 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 Class I noncompliance began on through where there were more than five at the facility in the span of two months, which resulted in two deaths and several injuries involving and .	{A 000}		
{A 025} SS=L	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the	{A 025}		

AHCA Form 3020-0001

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

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{A 025}	Continued From page 1 condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.	{A 025}		

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{A 025}	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision and follow its own policies and procedures for 8 out of 25 sampled residents that had and sustained injuries (1, 2, 3, 4, 5, 6, 8, 22) Residents 1, 2, 3, 4, 5 and 6 needed to be transferred to the hospital. Resident 1 and Resident 2 had , sustained injuries and in the hospital the following day. Resident 3 had unexplained ankle, and injuries and needed surgery to repair a . Residents 8 and 22 had unwitnessed . Findings included: 1) A review of Resident 1's hospital record showed the Resident was brought to the emergency department via (Emergency Medical Services) on following an unwitnessed at the facility and a alert was activated after the Resident became acutely , during transport. The Resident developed , right gaze deviation, and left upper extremity and was admitted in critical condition due to sudden clinical deterioration. The physical examination revealed over the left , and to the anterior left ; diagnoses included Type A , , hematoma, , , acidosis and . Further review of the hospital record revealed Resident 1 expired on . A review of Resident 1's nurse's notes dated at 11:10 AM showed,"CNA (Certified	{A 025}		

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{A 025}	Continued From page 3 Nurses Aide} [Caregiver Staff G] reported that she was assisting Resident 1 to get dry in the shower when the Resident had sudden and she was unable to hold the Resident on time resulting in the Resident falling. Further review showed Resident 1 was from a cut to the left and a to the left , she was weak, and unable to remember what happened. transported the Resident to the hospital" A review of Resident 1's nurse's notes dated showed that Resident 1's daughter notified the facility that Resident 1 , at the hospital on at 1:00 AM. Interviewed on at 1:39 PM when she was asked about Resident 1's Staff G, a Caregiver, stated that Resident 1 needed assistance with bathing and in the shower after she had finished bathing her. Staff G stated, "She needed assistance with bathing. I had finished giving her a bath and was drying her when she suddenly and I could not hold her. I removed the shower chair and asked her to stand to dry her , she was holding onto the rail, but she just dropped. She was when rescue arrived. If a resident cooperates and can stand up, I remove the chair when drying" A review of Resident 1's care plan dated showed the Resident needed assistance with bathing and . A review of Resident 1' health assessment dated revealed diagnoses of essential with , , with , Physical limitations showed gait imbalance, use	{A 025}		

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{A 025}	Continued From page 4 of a rolling walker, wear glasses. ␣ status showed forgetfulness episodes. precautions were indicated. The activities of daily living (ADL) showed the Resident needed assistance with bathing and ␣. The Resident needed assistance with self-administration of medication. A review of the facility's Resident Supervision Policy and Procedure showed, "Procedure, 2. Implementation: Residents who require assistance with mobility or personal care must never be left unattended in unsafe situations (e.g., on the toilet, in the shower or in a wheelchair without the brakes applied" 2) A review of Resident 2's emergency medical service's run record dated revealed the Resident was transported from [Facility] to the hospital center after she from a chair and sustained a injury. Further review showed that an with was noted above the left ␣ from the . A review of Resident 2's hospital record showed the Resident was brought to the emergency department via on from [facility] after sustaining a from a chair with injury. Emergency department physician notes revealed Resident 2 was unresponsive on arrival with airway compromised, fixed, dilated right pupil , to light and constricted left pupil with minimal response to light, over left and left cheek. CT imaging of the , C- , and CTA revealed large ␣ along the right hemisphere with extension to the falx, tentorium, significant right to left shift and complete effacement of cortical suici and right lateral ventricle.	{A 025}		

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{A 025}	Continued From page 5 Further review of the hospital record revealed Resident 2 expired on . A review of the facility's nurses notes for Resident 2 dated at 4:06 PM showed the Resident was transferred to the hospital via 911 due to a . The Resident was in the activities area and lost her balance when trying to sit on a chair, falling forward with her . to the left side of the forehead. A review of Resident 2's nurse's notes dated at 2:05 PM showed the Resident's family notified the facility that Resident 2 had , at the hospital on at 12:20 PM. According to Harvard Health, "Most result from to the . The damages tiny veins within the meninges. In young, healthy people, is triggered usually by a significant impact. In contrast, older people may after only a minor . For example, it may happen from falling out of a chair. An acute hematoma is that develops shortly after a serious blow to the . accumulates rapidly, causing pressure to rise within the . This can result in loss of , , or " A review of the facility's incident report dated at 3:30 PM revealed that Resident 2 lost her balance and when trying to sit on a chair, hitting her on the left side. Further review showed that the caregiver, Staff I, "Failed to ensure the Resident was seated before turning and leaving; [Staff I] stated that she turned her on the Resident before sitting her on the chair and the Resident hitting her on the	{A 025}		

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{A 025}	Continued From page 6 wheelchair" Interviewed on at 1:30 PM when asked about the reason for the termination of Staff I 's employment the Administrator stated that she resigned after she improperly assisted a resident resulting in a . The Administrator stated, "It was because of [Resident 2]'s . She did not transfer her properly. We offered her training, but she refused" A review of Resident 2's health assessment dated showed diagnoses of , . Physical limitations showed, "She is elderly, frail patient with gait abnormality" The status showed . Nursing requirements showed," As per protocol" Special precautions showed and precautions. The activities of daily living (ADL) showed the Resident needed assistance with all ADL, ambulation, bathing, eating, self-care, toileting, transferring and needed assistance with self-administration of medication. 3) A review of Resident 3's hospital record showed the Resident arrived at the emergency department from [Facility] via ambulance on with unexplained to the and left upper , , and to the left with , . The facility staff reported to (Emergency Medical Services) that she did not . The Resident was diagnosed with left , significantly angulated and displaced acute , involving the and with suggested underlying ligamentous injury. Further review revealed Resident 3 required	{A 025}		

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{A 025}	Continued From page 7 inpatient admission for , control, orthopedic management of a displaced and further evaluation of possible unwitnessed versus neglect/ in the [Facility] setting. According to the Cleveland Clinic, "A , significantly angulated displaced of the is a severe type of that involves multiple breaks in the bone and significant angulation. These are usually caused by severe , such as car accidents or high and often require surgical intervention" A review of the facility's nurse's notes for Resident 3 dated at 9:00 AM showed the Resident was transferred to the hospital via ambulance due to left and to the upper , . Resident referred to , to left . No recent . Further review of Resident 3's record showed no documentation for of the left ankle on . Interviewed on at 7:11 AM when asked about Resident 3's injuries Supervisor Staff C, a Caregiver, stated that on at around 2:40 AM Staff X sent her a picture of [Resident 3]'s ankle; the Resident was complaining of , on her and she decided to put the Resident to bed because she only complained of , when "She put her down". Staff C further stated that on the following day, on at around 2:30 AM Staff F noticed that Resident 3 had a and after examining her she decided that it was not significant, but she took a photograph of the Resident's . Staff C stated," To protect myself" Staff C further recounted that later	{A 025}		

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{A 025}	Continued From page 8	{A 025}		

on that day, at around 6:00 AM Staff F reported that she had found Resident 3 on the floor and she asked Staff E to assist them to get Resident 3 off the floor.
Staff C further stated that she had not reported her earlier observation of the Resident's because she thought it was not related to the incident. Staff C stated, "I was asked to write the report at the end of my shift, and I did not mention the on the report because she had it before, before she was found on the floor. I don't believe she ; she was right next to the bed and wrapped in the sheets, I believe she slipped off the bed. She has a narrow bed, a regular bed. After I went home, I thought about it and sent the picture of her to [Supervisor Staff J]. I didn't do it before because I thought it was not significant, it could have been , and she had it before she was found on the floor. She was put in bed. Later a medication technician [Staff L] came to say that the Resident's arm did not look good, and she should go to the hospital. No, she did not have a , , she had no injuries to her "

Interviewed on at 8:25 AM- Staff E stated," I was making the rounds with the nightshift staff and found [Resident 3] on the floor; [Staff C] was there, and [Staff F] called me to help get [Resident 3] off the floor. She was complaining of , in her arm. She wanted to keep the door closed, sometimes she didn't want to shower, she was like that since she arrived"

Interviewed on at 9:00 AM the Administrator stated, "I should be called if a resident is found on the floor, or [the Director of Resident Services]. I don't know if [the previous Director of Resident Services] documented it, she quit on the same day AHCA was here the last

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{A 025}	Continued From page 9 time" Interviewed on at 12:16 PM the Administrator denied that Resident 3 had a . The Administrator stated, "No, she did not . Not that I know of" When she was asked to explain Resident 3's injuries the Administrator stated that she could not. The Administrator stated, "I found out when DCF (Department of Children and Families) came in. The hospital notified DCF. She went to [Hospital] No ankle, a arm and upper , . Yes, DCF validated it. Staff C was the shift supervisor" Asked if Resident 3 was evaluated when she was found with a ankle and in , on the Administrator stated," I don't know. Maybe they called the nurse. I believe they may have contacted the nurse. A lot of documentation is missing because we had a staff member that instead of filing, she removed documentation from the records. On [Staff F] and [Staff E] were there but they could not explain how [Resident 3] rolled out of bed when she had bedrails" A review of Resident 3's health assessment dated showed diagnoses of displaced of shaft of left arm, , type 2, , high , . Physical limitations showed the Resident needed assistance with ambulation. The status showed alert and oriented to person. Nursing requirements showed physical/ , and assistance with activities of daily living. Special precautions showed precautions. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, bathing, , self-care, toileting	{A 025}		

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{A 025}	Continued From page 10 and transferring. The Resident needed assistance with self-administration of medication. Interviewed on at 11:33 PM [DCF Investigator] stated that complaint allegations pertaining to lack of resident supervision were substantiated, and Resident 3 was injured a day before she was sent to the hospital. [DCF investigator] further stated that the facility staff did not know what had happened to Resident 3, and it took too long to send the resident to the hospital. The DCF investigator stated, "They (staff) were not sure what happened to the Resident. I substantiated that. They (Staff) did not say what happened. When you see an injury, you have to report it. It took too long, more than 24 hours." 4) A review of Resident 4's nurse's notes dated at 7:27 PM showed "Late entry. Resident sent to [hospital] due to . Resident son was notified" A review of Resident 4's nurse's notes dated at 2:50 AM showed, "Late entry. Resident arrived from [hospital] Son was notified of arrival" A review of Resident 4's nurse's notes dated showed, "Resident returned from [Hospital] via ambulance, vital signs within normal limits. New medications were ordered , 325 mg, oral tablets every 6 hours as needed for , , Cefradin 300 mg oral 1 capsule every 12 hours duration 2 days, 100 mg oral 1 capsule 2 times a day for 7 days." A review of the facility's internal incident report dated at 6:35 PM showed Resident 4	{A 025}		

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{A 025}	Continued From page 11	{A 025}		

had an unwitnessed , hit her on the floor and sustained to the forehead. Further review showed Resident 4 stated that she at the nurse station after she tripped over another residents' walker and hit her on the floor. 911 was activated.
Further review of the facility's post report showed that increased supervision, better assessment of the surroundings and staff training on resident supervision and assistance were required.

A review of Resident 4's Service Care Plan dated showed she needed assistance with ambulation, bathing, , toileting and transferring.

A review of Resident 4's health assessment dated showed diagnoses of , , Type 2, and . Physical limitations showed slow and steady. The status showed , , alert and oriented to person. Nursing requirements showed medication management, half bedrails for safety. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, bathing, , self-care, toileting, transferring and grooming.

A review of the facility's Policy and Procedure revealed, "If a patient is at risk, these interventions will be implemented based on the above-mentioned criteria: Maintain environment free of obstacles (At all times)"

Interviewed on at 9:00 AM when asked about Resident 4's on and about nurse's notes dated showing the Resident returned from the hospital via

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{A 025}	Continued From page 12 ambulance with orders for , medication the Director of Resident Care stated, "I'll have to check my notes; I am not sure. She ended up having the " Interviewed on at 3:40 PM the Administrator stated that Resident 4 at the nurse station when she tripped into another resident's wheelchair and the staff could not reach her in time. 5) A review of Resident 5's nurse's notes dated at 1:05 AM showed," Resident sent to the hospital. Family was called and notified" A review of Resident 5's nurse's notes dated showed," Resident returned to the facility via ambulance. Patient stable, family was notified" A review of the facility's internal incident report log showed Resident 5 had a and sustained injuries to his . A review of Resident 5's health assessment dated showed diagnoses of 's and . Physical limitations showed bedbound, generalized . status showed alert and oriented to person. Nursing requirements showed medication administration. Special precautions showed precautions. The activities of daily living showed the Resident needed total care with ambulation, bathing, , selfcare, toileting and transferring, needed assistance with eating. The Resident needed medication administration. Interviewed on at 3:40 PM the Administrator stated Resident 5 in his room	{A 025}		

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when trying to go to the bathroom unassisted and was transported to the hospital with to the , right cheek and the right .

6)
A review of Resident 6's nurse's notes dated at 3:00 PM showed," Resident sent out to [hospital]. Family notified"

A review of Resident 6's nurses' notes dated at 9:35 PM showed, "Resident returned from the hospital via ambulance. Family notified. New orders received"

Interviewed on at 12:00 PM, the Administrator stated that Resident 6 when she tried to sit and the staff failed to lock the wheels on her wheelchair. The Administrator further stated that Resident 6 had to the of her but did not have any and returned from the hospital on the same day.

A review of Resident 6's Service Care Plan dated showed she needed assistance with ambulation, bathing, transferring, toileting and self-care.

A review of Resident 6's health assessment dated showed diagnoses of with

Physical limitations showed uses wheelchair for ambulation propelled by staff. The status showed , due to . Nursing requirements showed half bedrails for safety. Special precautions showed precautions. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, bathing, , self-care, toileting and transferring. The Resident needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 025}	Continued From page 14 assistance with self-administration of medication. A review of Resident 6's Risk Intervention dated showed a moderate risk level of and the following interventions: Increase supervision and assistance, bedside sitting, personal care and toileting as appropriate. A review of Resident 6's Assistive Device Consent for rolling walker and wheelchair dated showed, "Facility will be responsible for ensuring assistive device is clean, free of hazards and its safe usage" A review of the facility's Resident Supervision Policy and Procedure showed, "Procedure, 2. Implementation: Residents who require assistance with mobility or personal care must never be left unattended in unsafe situations (e.g., on the toilet, in the shower or in a wheelchair without the brakes applied" 8) A review of the facility's internal incident report dated at 3:10 PM revealed that Resident 8 had an unwitnessed . Further review revealed Resident 8 was found on the floor next to her bed complaining of , in the . Further review of the incident report revealed that more frequent rounding was needed. 22) A review of the facility's internal incident report dated at 6:56 AM revealed that Resident 22 had an unwitnessed . Further review showed Resident 22 was found on the floor in his room with a to his right	{A 025}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 025}	Continued From page 15 , local care was applied, the doctor was notified, and , of the were ordered. A review of the facility's Resident Supervision Policy and Procedure revealed: Purpose: "The purpose of this policy is to ensure that all residents receive the appropriate level of supervision needed to maintain their safety, dignity, and independence while residing in the facility. Staff are expected to provide oversight that is consistent with each resident's service plan and level of care. Training: All direct care staff will receive training upon hire and annually on proper supervision, prevention, and recognizing changes in conditions that may require increased oversight. Documentation: If an incident occurs (, injury, etc.) staff must document the event, notify the nurse or the Administrator, and review whether the current supervision plan remains appropriate" A review of the facility's Policy and Procedure revealed, "The following interventions apply to all patients, as applicable: 4. Lock all movable equipment before transferring patients" A review of the facility's Assistive Device Policy and Procedure showed: 3- Direct Care staff should observe the Resident to ensure the device is used correctly to ensure safe usage. 4-Direct Care staff are responsible for ensuring the safety of the residents. 5- Direct Care staff should know how to operate and utilize the equipment to safely assist the residents Interviewed on at 6:22 AM Staff X stated that she was trained by another staff member that residents should always be	{A 025}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 025}	Continued From page 16 supervised when assisting with showering and the shower chair should not be removed. Interviewed on at 7:10 AM Staff Z stated she had only received one week of on-the-job orientation by another staff. She denied receiving training on assisting residents with ADL and preventing . "There is a code of silence here after incidents with residents" Interviewed on at 12:45 PM the Administrator stated that the facility was increasing their staffing to improve resident supervision, but it had been difficult to recruit . Class I Uncorrected	{A 025}		
{A 079} SS=G	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539	{A 079}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 079}	Continued From page 17 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be	{A 079}		

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SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 079}	Continued From page 18 physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the	{A 079}		

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{A 079}	Continued From page 19 requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.	{A 079}		

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{A 079}	Continued From page 20 (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure adequate and sufficient staff were available to meet the scheduled and unscheduled needs for three Residents (#3, #5, #22) who had with , including a , and a . Resident #3 needed assistance with activities of daily living was found on the floor wrapped in a sheet overnight. Resident #5 was under hospice care and needed total care was found on the floor overnight by Staff N (Home Health Aide). Resident #22 was under hospice care and had full bedrails when found on the floor. The facility failed to ensure adequate and sufficient staffing overnight for the scheduled and unscheduled needs for 150 residents for more than 60 days after Resident #3 was found on the floor. Findings: 1) A review of the staffing pattern dated showed only six employees on the overnight shift from 11:00 PM-7:00 AM when Resident #3 was found with a at 2:55 AM and on the floor at 6:00 AM on . A review of the facility's census dated showed 156 residents including two in the hospital at the time of the incident.	{A 079}		

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SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 079}	Continued From page 21 A review of Resident #3's hospital records dated showed the following: " female presents from her nursing facility via ambulance with a chief complaint that they found her with the to the left upper , and left . Nursing staff told ambulance crew that patient did not . Due to patient's , she does not recall what happened. Patient does not ambulate. left intra- OCL placed by tech case discussed with the on-call surgery who evaluated the patient." A review of Resident #3's progress notes dated showed: "Resident transferred to hospital via ambulance due to left . Vital signs taken , - . Resident referred to to left . No recent . Resident left facility at 8:33 AM in stable condition." However, there was no mention of to the , and ankle. According to the Cleveland Clinic, a broken , or , is a common injury that can affect any of the 10 bones that make up your and . The is most often affected. on an outstretched are the most common cause of a broken . You should always seek medical attention for a broken to receive a proper diagnosis and treatment. Intra- : A that extends into your , . : A that involves a bone that is broken into more than two pieces. How can you tell if your is broken? Severe and persistent . A review of Resident #3's health assessment dated showed diagnoses of displaced	{A 079}		

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
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 079}	Continued From page 22	{A 079}		

of shaft of left arm, , Type 2, . The physical status showed assistance with ambulation. The status showed alert and oriented times one. The nursing status showed assistance with activities of daily living. The Resident had precautions. The activities of daily living showed assistance with ambulation, bathing, , grooming, toileting, transferring and independent with eating.

2)

A review of Resident #5's progress notes dated showed the resident was transported to the hospital. However, no description of what occurred.

A review of Resident #5's Adverse Incident Reporting Systems database documented that the resident was found on the floor by Staff N (Home Health Aide) around 12:20 AM on , with on the top of the , right cheek, and above the left .

A review of the staffing pattern dated for the overnight shift from 11:00 PM to 7:00 AM showed only seven employees on schedule.

A review of Resident #5's health assessment dated showed a diagnoses of and . The physical status showed bedbound. The status showed awake, alert and oriented times one. The resident had precautions. The activities of daily living showed total care with ambulation, bathing, , self-care, toileting, transferring, and assistance with eating.

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{A 079}	Continued From page 23 According to the Cleveland Clinic, can be minor, like nicks from shaving or paper cuts, But when they're larger or deeper, they can be much more serious. Recognizing when a is self-treatable and when they need professional medical care can make a big difference for you or someone you care for. 3) A review of the facility's incident/accident report documented an unwitnessed involving Resident #22 who was under hospice care on at 6:56 AM with full bed rails: "Resident was found on the floor next to bed. Full side rails were up. observed on right . aid was [on place]. Hospice care [manager] was called. Nurse was sent to evaluate resident. No apparent injuries observed. New order from hospice doctor for , of right to rule out . [Son] was notified by hospice nurse." A review of the overnight staffing schedule dated showed only seven employees, including Staff C (Home Health Aide) for the overnight shift from 11:00 PM-7:00 AM. when Resident #22 was found. 4) Observation on at 6:00 AM found only five employees in the facility for 11:00 PM-7:00 AM shift. A review of the staffing pattern for the overnight shift (11:00 PM to 7:00 AM) for , , showed six Staff members: C, Staff D, Staff V, Staff W, Staff Z, and Staff Y (Home Health	{A 079}		

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{A 079}	Continued From page 24 Aides) were on schedule to work. However, only five staff members were present: Staff C, Staff D, Staff F, Staff V, and Staff Y. A review of the facility census dated 11/03/2025 showed 150 residents, including eight in the hospital and one with family. Interviewed on at 6:37 AM Hospice Care Certified Nursing Assistants on the overnight shift stated on the West Wing that they reported to the facility shift supervisor, Staff C (Home Health Aide) that there was not enough facility staff during the 11:00PM to 7:00 AM shift. The Hospice Care Certified Nursing Assistants stated further, "There should be more [facility] staff present to better take care of the residents. We need more staff to help with the residents." Interviewed on at 4:52 PM when informed that there were five employees with 151 residents and insufficient staff on the overnight shift, the Administrator acknowledged that there were insufficient employees. Interviewed on at 10:00 AM the Administrator stated that she was going to increase the overnight shift to 10 employees. Uncorrected Class I	{A 079}		
{A 162} SS=E	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,	{A 162}		

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
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

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{A 162}	Continued From page 25 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. (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	{A 162}		

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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 162}	Continued From page 26	{A 162}		

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 , , ( ), 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

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SEASONS GARDENS SENIOR RESIDENCE	**17250 SW 137 AVENUE MIAMI, FL 33177**

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{A 162}	Continued From page 27	{A 162}		

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 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 observation, record review and interview, the facility failed to have an accurate health assessment for 2 out of 25 sampled residents (20, 21).

Findings included:

20)
A review of Resident 20's health assessment dated showed diagnoses of , high . Physical limitations showed uses walker for ambulation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968608	A. BUILDING: _____ B. WING _____	R 11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 162}	Continued From page 28 status showed , , , with behavioral disturbances. Nursing requirements showed "None" Special precautions showed precautions. Activities of daily living (ADL) showed the Resident was independent with ambulation, , eating, self-care, toileting and transferring, needed assistance with bathing. The Resident needed assistance with self-administration of medication. Observation on at 8:53 AM revealed that Resident 20 was using a walker to enter the bathroom. 21) A review of Resident 21's hospital emergency department report and visit instructions dated showed diagnoses of lower extremity , , (,), , , , atelectasis and patient instructions for the use of , socks. Observation on at 8:20 AM showed that Resident 21 was sitting in her room awake and was not wearing socks. Further observation revealed a handwritten sign posted on the residents' closet door reminding staff that the Resident needed to wear , socks (Photographic evidence obtained) Interviewed on at 8:25 AM Resident 21 stated that she never wore socks. Interviewed on at 8:31 AM when asked if Resident 21 had orders for , socks Supervisor Staff U stated, "Yes, she had ankles, and the ordered , socks"	{A 162}		

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{A 162}	Continued From page 29 A review of Resident 21's health assessment dated showed diagnoses of essential [illegible] 6 and abnormal posture. Further review of Resident 21's record showed no documentation for lower extremity [illegible] atelectasis and indications for [illegible] socks. Interviewed on at 4:52 PM when she was informed regarding the inaccurate heath assessments for Resident 20 and Resident 21 the Administrator stated that Resident 21 had [illegible] socks. Uncorrected Class III	{A 162}		
{A 165} SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse	{A 165}		

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{A 165}	Continued From page 30 incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and	{A 165}		

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{A 165}	Continued From page 31 Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a report to the Agency about a resident's adverse incident within 1 business day	{A 165}		

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{A 165}	Continued From page 32 for 1 out of 25 sampled residents (Resident 3) Findings included: A review of Resident 3's nurse's notes dated at 9:00AM revealed that the Resident was transferred to the hospital emergency department via (emergency medical services) with unexplained injuries including to the and a that required surgical intervention. A review of the facility's AIRS (Adverse Incident Report System) showed a submission date of for Resident 3's adverse incident on (Report# 678518). A review of Resident 3's nurse's notes dated revealed that (emergency medical services) were activated when Resident 3 became unresponsive and was transported to the hospital. Interviewed on at 11:40 AM when she was asked what happened to Resident 3 on the Director of Resident Care Staff B stated that the Resident was not breathing. She stated, "Staff J found her and called for a nurse. I gave her . I brought out the (Automated External Defibrillator) She was transported by to the hospital. When asked if an adverse incident had been reported the Director of Resident Services Staff B stated, "We have not done that yet." Interviewed on at 4:52 PM when asked about Resident 3's incident on the Administrator stated, "I observed the situation. I believe the resident was convulsing. The staff screamed for help and the Director of Resident	{A 165}		

Agency for Health Care Administration

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{A 165}	Continued From page 33 Care Staff B ran and got the resident. When I came out of the office, the Director of Resident Care was doing , and 911 was called. I did not file an adverse incident report. Why would I file an adverse incident? I still have time. Do I have to file one?" A review of AIRS showed that Resident 3's adverse incident on was not reported. Uncorrected Class III	{A 165}		