

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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
ZZ821	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/SingleSignOnPo rtal. 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?N o=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/SingleSignOnPo rtal.	ZZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
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	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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	
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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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	
ZZ821	Continued From page 3 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 observation, interview and record review, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after a resident experienced a with injuries that resulted in a transfer to a hospital for 1 of 11 sampled residents (#16) and when law enforcement responded to the facility after 1 of 11 sampled residents alleged (#3.) Findings: 1. During an interview on at 10:32 AM, resident #3 was seen sitting in a wheelchair in the main lobby area of assisted living. The resident recalled that on at about 5 AM, a female caregiver, name unknown, made the resident take a shower even though she said no and while doing so the caregiver grabbed her , causing them both to . A review of resident #3's health assessment form, dated , revealed the resident needed assistance with bathing. A review of a facility note, dated , revealed nurse D documented that resident #3 showed her	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
ZZ821	Continued From page 4 on both of her and said, "the girl came this morning and forced me into the shower pulling on my arms to make me get a shower." During an interview on at 11:15 AM, the Administrator said law enforcement responded to the facility and investigated the resident's allegations. The Administrator then said the required preliminary and full reports were not submitted when law enforcement responded. A review of a law enforcement report, dated , revealed an investigation into the allegations was initiated. 2. A review of resident #16's record revealed an admission date of . The resident had a medical history of unsteady gait and . Her activities of daily living revealed she needed supervision with ambulation. A facility note dated at 11:54 AM, read resident was found in her room sitting on the floor in a puddle of by her bed. The resident was unable to state how she . The note continued to read that resident was noted with a to her left , to the left palm of her , on her left , and small hematoma with on the left side of her forehead. Resident denied , at the time of the incident. Emergency Medical Services was called, and the resident was transferred to Orlando Health hospital in Lake Mary. A facility note dated 11/3/25 at 12:24 PM, read staff responded to residents' room due to a between her bed and nightstand. The note continued to read that the resident was lying in her bed with her drawn up, dark , noted to her left , and when the resident	ZZ821	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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	
ZZ821	Continued From page 5 moved her left , she cried out in , and grabbed her , 911 was called and resident was transferred to Advent Health Orlando hospital. There was no documentation of adverse incident reports submitted regarding the residents' and following hospital visits on and On at 1:07 PM, the findings were discussed with the Administrator, who said no incident reports were submitted for resident #16's on the AHCA website. Unclassified	ZZ821			
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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	
ZZ875	Continued From page 6 . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKMONTE VILLAGE OF LAKE MARY-CORDOVA

**1001 ROYAL GARDENS CIR
LAKE MARY, FL 32746**

(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
ZZ875	Continued From page 7 and provides, or is designated to provide, specialized care for persons with _____'s or related forms of _____, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of _____-specific training. Such training must include, but is not limited to, understanding _____ and related forms of _____, the stages of _____'s _____, communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning _____. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or _____-on experience to help develop and refine the employee's skills for caring for a person with _____'s _____ or a related form of _____. The continuing education must cover at least one of the topics included in the _____-specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility	ZZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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	
ZZ875	Continued From page 8 administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , must complete the training required in this section before . Proof of completion of equivalent training completed before , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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
ZZ875	Continued From page 9 department under subsection (6). This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 6 sampled staff (A, N, O) completed a 1-hour training on _____'s and related forms of (ADRD) provided by the department of elder affairs within 30 days after beginning employment. Findings: A review of caregiver A's personnel record revealed a hire date of _____. A review of caregiver N's personnel record revealed a hire date of _____. A review of caregiver O's personnel record revealed a hire date of _____. Continued review of the records revealed none of them contained documentation to indicate the caregivers completed a 1-hour training on ADRD provided by the department of elder affairs. During an interview on _____ at 12:45 PM, the Business Office Manager confirmed the findings. Class III	ZZ875		
A 000	Initial Comments A complaint investigation (2025014555) and a generator monitoring visit were conducted at Grand Living Park at Lake Mary on _____, _____, and _____. Deficiencies were identified at the time of survey.	A 000		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 008 SS=D	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 008	Continued From page 11 (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of require such	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 008	Continued From page 12 assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations. 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living. 3. Any nursing or , , services required by the individual. 4. Any special diet required by the individual. 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication. 6. Whether the individual has signs or symptoms of , , or any other communicable , which are likely to be transmitted to other residents or staff. 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 008	Continued From page 13 medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 008	Continued From page 14 for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to obtain an AHCA Form, 1823 Health Assessment that was completed by the healthcare provider as required for 1 of 11 sampled resident (#9). Findings: A record review of resident #9 revealed a 1823 health assessment with an incomplete medical certification missing the name of the examiner, medical license, title of examiner, telephone number, and address. On at 3:15 PM, Nurse I was asked if a new 1823 was obtained after resident #9 returned	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 008	Continued From page 15 from the hospital on On at 3:20 PM, the Administrator provided an updated 1823 dated Further review revealed the address of examiner was blank. On at 3:30 PM, the Administrator was made aware the new 1823 provided was incomplete due to the missing address of the examiner. (photographic evidence obtained) Class III	A 008		
A 025 SS=G	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 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	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 16 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. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to provide adequate supervision to prevent resident to resident ... for 3 of 3 sampled residents (#5, #9, #17);	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
A 025	Continued From page 17 resulting in a with injury (#9). Findings: 1. Review of resident #9's 1823 health assessment indicated a medical history of of , alert and oriented to self, identified as a risk, and requires assistance with ambulation and transferring. A facility note on at 1:34 PM read, resident returned to facility from Encompass Rehab. A facility note on at 8:48 AM read, visited resident at Encompass. She is doing well with walking with walker/cane/using wheelchair for longer trips. A facility note on at 10:43 AM read, spoke with case manager and resident is ready for discharge. A facility note on at 2:27 PM read, the family of resident called to say resident is doing well with surgery and will be going to rehab for discharge on . A facility note on at 3:01 PM read, spoke with family of resident who advised she did have a and will have surgery in the morning. A facility note on at 10:09 AM read, resident was in the activities area and was arguing with another resident (#5). The other resident was seated and they grabbed each other's and were pulling (as seen from the nursing station). Resident lost her balance and	A 025	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKMONTE VILLAGE OF LAKE MARY-CORDOVA

**1001 ROYAL GARDENS CIR
LAKE MARY, FL 32746**

(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 18 to the floor and landed on her left side. Resident kept saying her hurt and she couldn't move. Emergency medical service called and transported. An incident report dated read or of bones or joints. Further stating, resident #9 and resident #5 became involved in a verbal disagreement regarding placement of resident #9's walker. Due to their, neither resident was able to safely or appropriately resolve the conflict. During the exchange, the residents reached toward one another and in the process resident #9 lost her balance and to the floor. An incident report dated at 9:55 AM read, witnessed, located in activity room, while sitting at nurses' station, heard a commotion and looked up to see resident arguing with a fellow resident. Nurse D and Nurse I were sitting at the nurses' station and saw incident that occurred near the activities table. No other staff were around residents at the time. On at 10:22 AM, resident #9 was observed sitting in the common area near resident #5 with her private sitter. At attempt was made to interview resident #9 regarding the incident, but the resident stated she does not recall the incident and does not remember. On at 10:24 AM, the private sitter stated she has been coming to sit with resident #5 for one year. Adding, since the incident and resident #5's return on to the facility she now comes every day. On at 12:14 PM, Nurse D stated she was sitting at the nurses' station, heard the	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
A 025	Continued From page 19 commotion, looked at the camera and heard yelling. Further stating, by the time she got there resident #9 was lying on the floor saying her left hurt and resident #5 was sitting down. On at 12:44 PM, the power of attorney (POA) stated he was displeased with the facility and could see how the incident happened. Further stating, he came to the facility after resident #9 returned from rehab to visit her. During his time at the facility, he observed the staff not watching the residents. Adding, another resident approached resident #9's wheelchair and resident #9 yelled out to not take her wheelchair. The POA continued by saying he thinks the facility is not properly watching the residents, so he called resident #9's private sitter to start coming daily. On at 1:59 PM, Nurse I stated resident #5 was sitting on her walker and resident #9's walker was next to resident #5. The residents started arguing as resident #9 wanted her walker. They grabbed each other's and started tugging and forth. That's when resident #9 lost her balance and. She stated she was sitting at the nurses' station when this happened. Adding, there was no immediate care staff in the vicinity as they were collecting residents for the activity. On at 2:30 PM, the Administrator stated the camera system in the memory care unit was recently updated to a new system and there was footage from the incident. 2. On at 11:51 AM, observation revealed resident #5 was sitting in the common area with other residents after returning from an outside	A 025	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 20 activity. Review of resident #5's 1823 health assessment indicated a medical history of lack of coordination, , ambulates with rollator/4wheeled walker, alert and oriented x2 (person and place), identified as a risk, requires supervision with transferring, and assistance with ambulation. An incident report dated at 9:54 AM read, resident to resident altercation, location activity room. While sitting at nurses' station, heard a commotion of 2 residents arguing. A facility note on at 12:03 PM read, voicemail left for POA to express the need to switch to adult diapers, if possible. A facility note on at 11:57 AM read, resident has been self-isolating in room complain of not feeling well. A facility note on at 3:29 PM read, last evening resident had an altercation with another resident at the dining room table, each resident shoving the table towards each other. Later in the evening another resident was passing by resident's door on his way to his apartment then she threw a vase from her apartment at the resident in the hallway and broke the vase missing the other resident. A facility note on at 11:01 AM read, spoke to POA about new medication and incident in the dining room. He stated that he is aware that resident #5 has a hard time with over stimulation and not handling her anger well. A facility note on at 12:42 PM read,	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 21 resident sat down at dining room table for lunch today, after about 5 minutes resident leaned over and pinched another resident. This resident then picked up her water glass and poured it all over another resident's plate of food. When staff asked why the resident did those things she denied doing them then stated she was being picked on by staff and wanted to go home. Staff moved the resident to another table and brought both residents fresh plates of food. This resident refused to eat, stating that she was being treated meanly and all the staff were lying about her and what happened. A facility note on _____ at 11:35 AM read, at approximately 11:30 AM resident was sitting at dining room table to another resident, they started arguing and resident #5 hit the other resident. When confronted by staff why she hit the other residents she stated, "because she can". Staff asked resident to leave the table to separate the two residents, resident #5 stood up and as she walked away she hit another resident in the _____ The other resident yelled out and when staff asked resident why she was behaving this way she stated that she wanted to leave the dining room. On _____ at 12:15 PM, Nurse D stated the _____ incident, resident #17 was loud at the table and he and resident #5 started shoving the table _____ and forth, telling each other to shut up. The staff intervened and was able to calm them down. Later that day resident #5 threw a vase from her room out into the hallway as resident #17 was passing by. His room is next to resident #5. On _____ at 1:15 PM, Nurse D stated there was no report completed for the incident on _____ between resident #5 and resident #17.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
A 025	Continued From page 22 On _____ at 2:08 PM, an attempt was made and voice message left to speak with resident #5's POA. On _____ at 2:50 PM, Nurse D was asked to identify the care staff involved in the incident, further stating it was a staff who is not employed. On _____ at 4:17 PM, Nurse I was asked about the incidents on _____ & _____, stating after review of the progress notes, "I did not work here. I can read it, but I can't speak it." Further stating, there were no incident reports completed for those dates. On _____ at 4:23 PM, the Administrator stated she would follow up on the 2 dates in question and pull the incident reports to provide the names of the other residents. On _____ at 4:30 PM, the Administrator stated she did not find any incident reports for the _____ and _____ events involving resident #5, adding she contacted the former health and wellness director who was unable to provide any additional information related to the incident reports. On _____ at 9:05 AM, the Administrator stated she was unable to find any reports or the staff who worked that day who may be aware of the incidents. The Administrator added she will review all the progress notes for the residents in Sienna around those dates to determine if she is able to identify the other residents involved. On _____ at 10:36 AM, the Administrator stated she was unable to find out who the	A 025	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 23 residents were in the _____ and incidents. On _____ at 11:21 AM, Nurse D was asked to review the progress notes for resident #5 to determine if she recalls who the other residents were. She stated I don't recall but I did hear about the _____ when she returned to work the next day. Further stating, someone is supposed to be in the common area with the residents at all times. If they leave the area, they're supposed to tell another staff member to come out. On _____ at 11:33 AM, Nurse I stated no is required to be out there in the common area. She explained she was about 40 -50 _____ away from the residents and would not have been able to intervene. Adding, I'm not aware if there's a policy which states someone has to be within reach. She stated if she had known about resident #5, she would have done things differently, providing no further clarification. On _____ at 12:25 PM, the Administrator stated the facility did not do service plans initially on the residents. Adding, they used to go by the residents' 1823 for care and recently started using service plans in _____. The Administrator stated there was nothing documented for resident #5's behavior and what the staff would do. She stated they would have just verbally told the staff. Review of resident #5's _____ service plan revealed there was no information listed for her behaviors or inventions put in place. On _____ at 3:15 PM, Caregiver M stated resident #5 gets agitated with other residents and gets aggressive. Adding, resident #5 does not like	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 24 loud noise. Resident #17 screams help all the time and resident #5 yells at him to shut up. Resident #17 has a sitter that comes in the evening and sits with him until he asleep and returns in the mornings to get him up to help with his screaming. Further stating residents #5 and #9 are both demanding and neither one will let things go. When resident #5 is out of her room, we watch her and try to keep her away from the residents like resident #17 and resident #9. Review of the facility's undated Incident Reporting policy states an incident report will be completed whenever an occurrence or event leads to an unintentional consequence or an unfortunate happening to a resident. Incidents involving residents' best practice is to evaluate daily and document for approximately 3 days from occurrence. Review of the facility's undated , Neglect, and , policy states identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as verbally aggressive behavior, physical aggressive behavior. The facility did not adhere to their Incident Reporting policy by completing reports for resident #5's , incidents, did not update the care plan for interventions or monitor for behaviors which might lead to conflict resulting in physical aggressive behaviors, or documentation in her progress notes the incident. 3. Review of resident #17's 1823 health assessment indicated a medical history of poor coordination, alert to self, moderate	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 25 , identified as a risk, and needs assistance with ambulation and transferring. A facility note on at 9:36 AM read, "Has caregiver come in the early morning and at bedtime. On at 1:15 PM, Nurse D stated there was no report completed for the incident on between resident #5 and resident #17. Further reviewed there was documentation in resident #17's progress notes for the incident. The facility failed to adhere to their policies as it relates to , neglect, , and incident reporting for residents #5, #9, and #17. (photographic evidence obtained) Class II	A 025		
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	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 052	Continued From page 26 that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying , medications. (e) Returning the medication container to proper storage. (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.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 052	Continued From page 27 (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , or , preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (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	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
A 052	Continued From page 28 advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to 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	A 052	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 052	Continued From page 29 in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's _____ control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the unlicensed caregivers (C and P) who assisted 3 of 5 sampled residents (#18, #19, #20) with medications followed the correct procedures. Findings: 1. During an interview on _____ at 10:41 AM, resident #18 said that on the previous evening a staff member entered her room with a cup of two pills and told her they were her medications. The resident said the staff member did not tell her the name and dosage of the pills. The resident said she told the staff member she was supposed to get four tablets. The resident said the staff member then told her to take them because they were listed under the resident's name, so the resident took them. The resident said she experienced tingling on her _____ after taking the medications. The resident said that a short time later a different staff member entered with a cup of medications. The resident said she told the staff member that she already took medications. The resident said the staff never told her the name and dosage of the medications. The resident said the tingling on her _____ was gone and she felt fine at the time of the interview.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
A 052	Continued From page 30 A review of resident #18's health assessment form, dated _____, revealed she needed assistance with self-administration of medications. A review of a medication incident report, dated _____ at 7 PM, revealed the resident was given the wrong medication. During an interview on _____ at 12:52 PM, caregiver P said that when she gave resident #18 the wrong medication, it was her first time working on the second floor. Caregiver P said that while she was preparing the medications at the cart, other residents kept approaching her. Caregiver P said that one of those residents kept talking about resident #18, while saying the resident's room number. Caregiver P then said that room number got in her _____, so she took the pills to that resident. Caregiver P said she handed the cup of pills to resident #18, who asked, "only one?" Caregiver P said she replied, "yes, you have more pills coming later." Caregiver P said she could not remember the name of the pills. Caregiver P then said she did not tell resident #18 the name and dosage of the pills. Caregiver P said she knew that she was supposed to take the medication packages to the resident, say the name and dose of the medication, then prepare them in the resident's presence. Caregiver P then said she did not do that in this instance because no other staff did either. 2. Observations made during a medication pass for resident #19 on _____ at 10:52 AM revealed unlicensed caregiver C prepared the medication at the cart, took the pill to the resident, and did not say the name and dosage of the	A 052	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 052	Continued From page 31 medication. 3. Observations made during a medication pass for resident #20 on _____ at 10:54 AM revealed unlicensed caregiver C prepared the medication at the cart, took the pill to the resident, and did not say the name and dosage of the medication. During an interview on _____ at 11 AM, unlicensed caregiver C said she did not prepare the medication in front of resident #19 because the caregiver prepared the medicine fast otherwise the resident called for it. The caregiver said she did not prepare the medication in front of resident #20 because the resident always closed her room door. The caregiver then said she did not say the name and dosage of the medication because both residents knew the medication. A review of the facility's undated policy on assisting with self-administration of medications revealed the facility would maintain medication standards consistent with and in compliance with the minimum standards required by statutes and rules. Class III	A 052		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 081	Continued From page 32 provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee 's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746	
(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)
A 081	Continued From page 33 orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who	A 081	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 081	Continued From page 34 have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER OAKMONTE VILLAGE OF LAKE MARY-CORDOVA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 ROYAL GARDENS CIR LAKE MARY, FL 32746		
(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 081	Continued From page 35 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 6 sample staff (A, N, O) completed the minimum required training. Findings: A review of caregiver A's personnel record revealed a hire date of . A review of caregiver N's personnel record revealed a hire date of . A review of caregiver O's personnel record revealed a hire date of . Continued review of the records revealed none of them contained documentation to indicate the caregivers received a minimum of 1 hour in-service training within 30 days of employment that covered resident rights in an assisted living facility and the facility's prevention policies and procedures. Additional review of caregiver A's and caregiver N's record revealed neither of them contained documentation to indicate the caregivers received 3 hours of in-service training within 30 days of employment that covered resident behavior and needs and providing assistance with the activities of daily living. During an interview on at 12:45 PM, the Business Office Manager confirmed the findings . Class III	A 081		