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
	AL11969102	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAGNOLIA AT MEASE LIFE	603 VIRGINIA ST DUNEDIN, FL 34698

(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 complaint investigation (complaint number: 2025018048) and a generator monitoring visit were conducted at The Magnolia at Mease Life on . Deficiencies were identified at the time of survey.	A 000		
A 076 SS=D	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at:	A 076		

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A 076	Continued From page 1 http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , , , staff trained in , , ( ) or a health care provider present in the facility, may withhold , , (, , , and). (b) In the event a resident is receiving hospice services and experiences or , , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by:	A 076		

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A 076	Continued From page 2 Based on observation, record review, and interview, the facility failed to ensure employees implemented a residents for one Resident (#1) of one sampled resident. Findings included: A self-reported adverse incident report dated , conducted on , revealed Resident #1 was found in the bathroom unresponsive at 3:20 AM by Staff B. Staff A proceeded to do , , on Resident #1. The report showed it was the emergency personnel that stopped the , , on Resident #1 after the paperwork showed Resident #1 had a . A review of witness statements of the event, conducted on , revealed there were two witness statements by Staff B and Staff C. Staff B wrote at 2:25 AM Staff B had seen Resident #1 in wheelchair putting on another shirt. Staff B wrote when walking at 3:20 AM to grab hangers, Staff B did not see Resident #1. Staff B wrote Staff B checked the bathroom and Resident #1 was leaned over and was purple and blue. Staff B wrote Staff B had called Staff C, Staff A, and the Nurse to help. Staff B wrote Staff B called 911 and Staff A and Staff B placed the resident on the floor. Staff B wrote Staff A started on Resident #1. Staff C wrote that Staff B called for Staff C to help with Resident #1. A record review of Resident #1's dated , conducted on , revealed Resident #1 had a form and Resident #1 wished to have	A 076		

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A 076	Continued From page 3 . A review of the retraining for , conducted on , revealed there were seventeen staff that were not trained out of twenty-five employees. A review of the / residents, conducted on , revealed that there were five residents that wished to have out of census of 28. During an interview with Staff B, conducted on at 1:45 PM, revealed Staff B stated around 2:20 AM on , the staff went to check on Resident #1 and checked on Resident #1 again at 3:20 AM. Staff B stated Staff B went in to put Resident #1's clothes away and the resident was in bathroom. Staff B stated when Staff B check on Resident #1, Resident #1 was black, blue, and purple. Staff B stated Staff B called for the other care Staff C, Staff A, and the Nurse. Staff B stated as soon as the other staff arrived, Staff B and Staff A placed Resident #1 on the floor. Staff B stated Staff A started . Staff B stated Staff B went to get the defibrillator and call 911. Staff B stated Staff B knows now what the red hearts on the residents doors mean now but did not know what the hearts meant during the time Resident #1 went through . During an interview with Staff C, conducted on at 12:03 PM, Staff C stated Staff C had gone into Resident #1's room with Staff B and Resident #1 was blue. Staff C stated Staff C went and told Staff A and the Nurse. Staff C stated Staff A called 911 and that Staff B was on the phone with the paramedics when Staff B came out of the room. At 2:45 PM, Staff C stated Staff C did not do anything or assist with anything until after	A 076		

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A 076	Continued From page 4 Resident #1 was . During an interview with Staff K, conducted on at 11:44 AM, Staff K stated the facility had red hearts on residents' rooms to note who was a . During an interview with Staff E, conducted on at 1:08 PM, Staff E was not able to identify what the red on the door meant (meaning no). Staff E went off memory and wrote the room numbers down on a sheet of paper at the start of his shift. During an interview with Staff F, conducted on at 1:15 PM, Staff F was not able to identify what the red hearts were on the residents' doors meant. During an interview with Staff I, conducted on at 3:02 PM, Staff I stated Staff I went by memory and the list of residents at the nursing office. Staff I was not able to identify what the red on the door meant (meaning no). Staff I stated there was nothing on the doors or in the apartments. During an interview with Staff G, conducted on at 3:05 PM, Staff G was not able to identify what the red on the door meant (meaning no). Staff G stated there were nothing on the residents' doors. A review of the policy and procedures (Issued:) showed "3. resident identification device is: a. A minature version of the state form (1886), d. Intended to provide a convienent and portable which travels with	A 076		

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A 076	Continued From page 5 the resident. e. so it can be seperated from the form. 4. If a resident has a the resident's chart will be flagged per community protocol to alert health providers." During an interview with the Wellness Director, conducted on at 11:44 AM, the Wellness Director stated Staff B went in to do rounds and Resident #1 was not in bed and called for Staff A, Staff C and the Nurse. Staff B and Staff A put Resident #1 on the floor because Resident #1 was in , , distress. Staff A started and Staff B called 911. The Wellness Director stated that no knowledge of what Staff C did. During an interview with the Administrator, conducted on at 11:44 AM, the Administrator stated the staff went to do rounds and Resident #1 was not in bed. Staff B called the nurse and Staff A. Staff A and Staff C arrived and put Resident #1 on the floor because Resident #1 was in , , distress. Staff A started . Staff B called 911. The Administrator stated she had no knowledge of what Staff C did but was present although not actively involved. Staff A was placed on immediate suspension and separated from employment. The Administrator stated there were hearts on residents' room doors to note who was a and a list by the defibrillator to note who was a and who wished for . The Administrator stated there was also a list of and residents in the Nurse Coordinator's room. At 2:06 PM, the Administrator stated that she had hoped all staff would be retrained on orders by the next staff meeting. Class II	A 076		

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