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
	AL11968323	A. BUILDING: _____ B. WING _____	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTATE AT HYDE PARK	2301 W PALM DR TAMPA, FL 33629

(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 077 SS=I	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must:	A 077		

AHCA Form 3020-0001

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

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A 077	Continued From page 1 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of	A 077		

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A 077	Continued From page 2 facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the Facility Administrator failed operate effectively, implement safety measures and manage facility	A 077		

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A 077	Continued From page 3 practices to ensure facility residents received appropriate care and services. The Administrator failed to ensure it's residents acquired appropriate assessments and ongoing monitoring to mitigate resident and injury. This failure to adequately assess residents following , lack of documenting , implementing safety plans and reevaluating residents with reoccurring placed all residents at risk for injury. Findings Include: A review of resident record for Resident's #6, #11, #14, #15, #17, #18, #19, # 20, #21 and #22 revealed that Resident #6, #11, #14, #15, #17, #18, #19, # 20, #21 and #22 had a total of fourteen unwitnessed within a selected thirty-day review period. Some of the resulted in hospitalizations, and . A record review conducted on of the facility's response policy, dated , revealed that staff present were required to Implement the temporary service plan- form (including intervention) and place it in the 24-hour report binder. The policy also noted the facility staff were to, enter an incident report into the incident reporting system. (Photographic evidence obtained) A record review of the files for Resident's #6, #11, #14, #15, #17, #18, #19, # 20, #21 and #22 revealed no evidence of the Temporary Service Plan- Form in the file. Further review revealed no evidence of an incident report being completed after each for Resident's #6, #11, #14, #15, #17, #18, #19, # 20 and #22. During an interview conducted on at	A 077		

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A 077	Continued From page 4 1:21 p.m. with the Administrator, the Administrator stated the facility does not perform a new risk assessment every time a resident . The assessment is conducted only when a resulted in injury. Furthermore, the Administrator stated nothing the facility implemented could 100% prevent . During an interview conducted on at 3:34 p.m. with the Administrator, the Administrator could not provide evidence of the Temporary Service Plan- Forms or incident forms for Residents #6, #11, #14, #15, #17, #18, #19, # 20, #21 and #22. Class II	A 077		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from	A 160		

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A 160	Continued From page 5 which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C.	A 160		

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A 160	Continued From page 6 (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's . . . prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 160		

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A 160	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log that included the discharge location and date of discharge for multiple entries on the log. Findings included: A record review of the facility's Admission and Discharge Log, conducted on , revealed that the Admission and Discharge Log was missing documentation. According to the facility's Admission and Discharge Log, there was no documentation of where residents were discharged to, and the date of discharge for multiple residents. Resident #8 was not documented as discharged on the Admission and Discharge log but was discharged from the facility on , per Resident #8's records. During an interview on at 3:30 p.m., the Administrator agreed the facility Admission and Discharge Log was missing documentation. Photographic evidence obtained. Class III	A 160		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth,	A 162		

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A 162	Continued From page 8 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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A 162	Continued From page 9	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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A 162	Continued From page 10 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 record review and interview, the Facility failed to maintain an updated and completed Agency for Health Care Administration health assessment form (AHCA Form 1823) for seven (Resident #7, #15, #17, #20, #21, #23 and #24) of twelve sampled residents. Findings Included: A record review for Resident #7, who was admitted on , revealed Resident #7's AHCA Form 1823 which was signed and dated on did not include the physician address	A 162		

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A 162	Continued From page 11 under the medical certification at the bottom of page 3. Further review of Resident #1's AHCA Form 1823 did not include special precautions on page 1. A record review for Resident #15, who was admitted on , revealed Resident #15's AHCA Form 1823 which was signed and dated on did not include a diagnosis, physical or sensory limitations or special precautions on page 1. Furthermore revealed, the AHCA Form 1823 did not identify if Resident #15 requires any assistance with ambulation on page 2. A record review for Resident #17, who was admitted on , revealed Resident #17's AHCA Form 1823 which was signed and dated on was missing the second page therefore did not identify if the Resident was receiving assistance with ADL's (Activities of Daily Living), residents diet, or if the individuals needs can be meet in an assisted living facility. A record review for Resident #20, who was admitted on , revealed Resident #20's AHCA Form 1823 which was signed and dated on was incomplete and did not identify Resident #20's Physical/Sensory Limitations. Furthermore, the AHCA Form 1823 did not include Hospice services under receiving Nursing/Treatment/ , , service Requirements. Resident #20 was admitted to Hospice on . A record review for Resident #21, who was admitted on , revealed Resident #21's AHCA Form 1823 was signed and dated on was older than the three years required for maintaining an AHCA Form 1823. Furthermore, Resident #21's AHCA Form 1823	A 162		

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A 162	Continued From page 12 was incomplete and did not identify if the Resident was receiving Nursing/Treatment/ , , service Requirements. Further review revealed Resident #21 was receiving Hospice services. A record review for Resident #23, who was admitted on , revealed Resident #23's AHCA Form 1823 which was signed and dated on was incomplete and did not identify if the Resident was receiving Nursing/Treatment/ , , service Requirements. Resident #23 was admitted to hospice on . A attempted record review for Resident #24, who was admitted on , revealed the facility did not maintain Resident #24's records including a AHCA Form 1823 for the required 2 years after discharge. During an interview conducted on at 4:30 p.m., with the Administrator, the Administrator agreed the AHCA Form 1823's for Resident #15, #17, #20, #21, #23 were incomplete and not up to date. The Administrator also agreed that she could not find the records for Resident #24. (Photographic Evidence Obtained) Class III	A 162		
A 000	Initial Comments A complaint investigation (2025018915) was conducted at Estate at Hyde Park on - . Deficiencies were identified at the time of the survey.	A 000		

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A 000	Continued From page 13 A Class I deficiency was found at Tag A0025. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. Estate at Hyde Park failed to provide adequate personal supervision and oversight required for each resident to prevent and implement interventions for residents at risk for . The Class I noncompliance began on . . The facility's Administrator was notified of the Class I noncompliance on at 3:30 p.m. The census at the start of the survey was 56. The following is a description of the deficiencies found at the time of the visit.	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	A 025		

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	AL11968323	A. BUILDING: _____ B. WING _____	12/29/2025

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A 025	Continued From page 14 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 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	A 025		

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A 025	Continued From page 15 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 review and interviews, the facility failed to provide adequate personal supervision and oversight required for each resident to prevent and implement interventions for residents at risk for for all 56 Residents. This lack of supervision, oversight and implementation of interventions for residents at risk for resulted in fourteen within a thirty-day period with some resulting in , and . The facility's lack of implementation of precautions and interventions before and after resident placed all residents at immediate risk of harm. Findings included: A review of the facility's response policy, dated , revealed that staff present were required to follow the procedure below: " Implement the temporary service plan-form (including intervention) and place it in the 24-hour report binder. " Enter an incident report into the incident reporting system. (Photographic evidence obtained) A review of a facility self-reported incident, dated , revealed that Resident #6 had an unwitnessed on at approximately 8:11 p.m., which resulted in a left , . (Photographic evidence obtained)	A 025		

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A 025	Continued From page 16 A review of Resident #6's undated Agency for Health Care Administration health assessment form (AHCA form1823), revealed that Resident #6 had a history of , was non-verbal, and required total care with ambulation. A record review of Resident #6's file revealed no evidence of the Temporary Service Plan-Form in the file after Resident #6's on . The record also contained no evidence of the incident report having been completed after Resident #6's on . A record review of Resident #11's progress notes revealed that Resident #11 had an unwitnessed on the following days: " at 7:50 p.m. Resident was found sitting on bedroom floor. No injury noted. " at 7:49 p.m. Resident was found sitting on bedroom floor. No injury noted. " at 2:56 a.m. Resident was found sitting on bedroom floor. No injury noted. (Photographic evidence obtained) A review of Resident #11's AHCA form1823 dated , revealed Resident #11 was a known risk. Further review of Resident #11's record revealed Resident #11 had a history of and and required assistance during ambulation. An observation of the facility's surveillance video dated at 3:31 a.m. was conducted on . The video surveillance revealed Resident #11 was standing by the bed, Resident #11 was attempting to get dressed, grabbed onto the wheelchair next to the resident and then backwards onto the bedroom floor. (Video evidence obtained)	A 025		

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A 025	Continued From page 17 A record review of Resident #11's file revealed no documentation of the on observed on surveillance video. Further review of Resident #11's record revealed no evidence of the Temporary Service Plan- Form for Resident #11 after the on , , , and . The record also contained no evidence of incident reports being completed after Resident #11's on , , , and . A review of Resident #14's undated progress notes revealed that Resident #14 had unwitnessed on the following days: o at 7:10 p.m., resulting in a small to top of right . o at 8:02 p.m., resulting in a large on the right and two lumps on right side of . (Photographic evidence obtained) A review of Resident #14's AHCA form1823 dated , revealed Resident #14 was a known risk. Further review revealed Resident #14 had a history of and required supervision during ambulation. A record review of Resident #14's file revealed no evidence of the Temporary Service Plan- form in the file after Resident #14's on or . The record also contained no evidence of completed incident reports after Resident #14's on or . A review of Resident #15's undated progress notes revealed Resident #15 had unwitnessed on the following days: o at 6:55 a.m.: Resident found lying on the floor at the of bed and under bed, curled up and calling out "Help me, get me	A 025		

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A 025	Continued From page 18 off the floor, I want to get in my bed." No injury noted. o at 6:27 a.m.: Resident found sitting on the floor between bed and window with against dresser. No injury noted. (Photographic evidence obtained) An observation of the facility's surveillance video dated at 10:18 p.m. was conducted on . The video surveillance video revealed Resident #15 lying on the bedroom floor at the of the bed with under the bed. (Video evidence obtained) A review of Resident #15's AHCA form1823 dated revealed Resident #15 had a history of . Further review revealed the AHCA form1823 was incomplete and did not indicate if Resident #15 was a risk or required assistance during ambulation. A record review of Resident #15 file revealed no evidence of the Temporary Service Plan- form in file after Resident #15's on or . The record also contained no evidence of the incident report being completed after Resident #15's on or . A review of Resident #17's undated progress notes revealed Resident #17 had an unwitnessed on the following day: o at 4:45 a.m. Resident observed walking past staff at which time was noted dripping from his forehead. (Photographic evidence obtained) A review of Resident #17's AHCA form1823 dated revealed Resident #17 had a history of . Further review of Resident #17's	A 025		

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A 025	Continued From page 19 AHCA form1823 revealed the document was incomplete and did not indicate if Resident #17 was a risk or required assistance during ambulation. A record review of Resident #17 file revealed no evidence of the Temporary Service Plan- form in file after Resident #17's on . The record also contained no evidence of the incident report being completed after Resident #17's on . During a tour of a common area on at 6:32 a.m., Resident #17 was observed with their pants down behind a piano and appeared to be . No staff members were present at that time. An interview was conducted with Resident #17's family member on at 10:37 a.m.. The family member stated Resident #17 required nine or ten stitches to the forehead after the on . An attempted record review regarding Resident #17 on was completed. No documentation was observed in the file related to the for Resident #17. A review of progress notes for Resident #18 revealed an unwitnessed on the following day: o at 5:52 a.m. Staff received a call while preventing another resident from a that the facility camera observed Resident #18 on the floor. No injury noted. No further description of the was documented. (Photographic evidence obtained) A review of Resident #18's AHCA form1823 dated , revealed Resident #18 was a known	A 025		

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A 025	Continued From page 20 risk. Further review of Resident #18's record revealed Resident #18 had a history of and required assistance during ambulation. A record review of Resident #18 file revealed no evidence of the Temporary Service Plan- form in the file after Resident #18's on . The record also contained no evidence of the incident report being completed after Resident #18's on . A review of Resident #19's undated progress notes revealed that Resident #19 had an unwitnessed on the following day: o at 6:41 a.m.: Resident #19 was found sitting on the floor between bathroom and bedroom. No injury noted. (Photographic evidence obtained) A review of Resident #19's AHCA form 1823 dated revealed Resident #19 was a known risk. Further review of the records revealed Resident #19 had a history of and and was independent with ambulation. An attempted record review of the Temporary Service Plan- Form for Resident #19 revealed no evidence of the form in the file after Resident #19's on . The record also contained no evidence of the incident report being completed after Resident #19's on . A review of Resident #20's undated progress notes revealed that Resident #20 had unwitnessed on the following days: o at 6:12 a.m.: Resident found on floor with bloody and right , o at approximately 9:34 p.m.: Resident was found on the floor beside bed, crying out in . Resulting in a on left	A 025		

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A 025	Continued From page 21 arm about the size of a quarter. o at 7:45 a.m.; Staff heard yelling and found resident on the floor. A scratch on the residents' left upper , a on left arm and lower left . o at 2:27 p.m., Resident #20 slipped off recliner chair. Resident was found lying on bedroom floor. Complaint of , in right . o at 4:15 p.m., Resident #20 had "3rd in 24hours today. " o at 1:15 p.m., Resident #20 found with to the left side of forehead. An observation of the facility's surveillance video dated at 10:00 p.m. was conducted on . The video surveillance revealed Resident #20 walked from the bathroom to a recliner chair, sat down at the of recliner, and forward onto the . (Video evidence obtained) A record review of Resident #20's progress notes revealed no documentation of the or stitches received on observed on surveillance video. An observation of the facility's surveillance video dated at 1:11 p.m. was conducted on . The video surveillance revealed Resident #20 stood up from the wheelchair and onto the floor. (Video evidence obtained) An interview was conducted with Resident #20's family member on at 9:25 a.m.. The family member stated Resident #20 had many and the last required Resident #20 to go to a local hospital and had received stitches to the .	A 025		

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A 025	Continued From page 22 An attempted record review was conducted regarding Resident #20 hospitalization. No hospital records were observed in the file for Resident #20. A review of Resident #20's AHCA form1823 dated revealed Resident #20 was a known risk. Further review of the records revealed Resident #20 required assistance with ambulation. A record review of Resident #20 file revealed no evidence of the Temporary Service Plan- form in the file after Resident #20's on , , the three on , , and . The record also contained no evidence of the incident report being completed after Resident #20's on , , the three on , or . A review of Resident #21's undated incident report revealed Resident #21 had an unwitnessed on the following day: o : with staff transfer. Resulted in a to right check and left . (Photographic evidence obtained) An observation of the facility's surveillance video dated at 7:45 a.m. was conducted on . The video surveillance revealed Staff K attempted to assist Resident #21 with transferring from bed to wheelchair. Both Resident #21 and Staff K were observed falling to the ground during the transfer. (Video evidence obtained) An interview was conducted on at 12:12 p.m. with Staff K. Staff K stated Resident	A 025		

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A	Continued From page 23 #21 onto Staff K. A review of Resident #21's AHCA form1823 dated , revealed Resident #21 was a known risk. Further review of the records revealed Resident #21 had a history of 's and required supervision with ambulation. A record review of Resident #21 file revealed no evidence of the Temporary Service Plan-Form in file after Resident #21's on . A review of Resident #22's undated progress notes revealed Resident #22 had unwitnessed on the following days: " : Resident has confirmed acute to right ,. " : Post day three. " : , (late entry) (Photographic evidence obtained) A review of a self-reported incident for Resident #22 dated , revealed that an unidentified staff found Resident #22 on at 8:30 p.m. lying on the floor near the toilet in the bathroom. No injuries were noted by the staff at that time. Staff assisted Resident #22 off the floor and to bed. A of the right , was confirmed by imaging on . (Photographic evidence obtained) A review of Resident #22's AHCA form1823 dated revealed Resident #22 had a history of and required supervision with ambulation. A record review of Resident #22 file revealed no evidence of the Temporary Service Plan-	A 025		

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A 025	Continued From page 24	A 025		

Form in file after Resident #22's on . The record also contained no evidence of the incident report being completed after Resident #22's on .

During an interview conducted on at 5:35 a.m. with Staff F (Caregiver), Staff F stated they did not feel like there was enough staff to meet resident needs on the night shift.

During an interview conducted on at 5:56 a.m. with Staff G (Caregiver), Staff G stated they did not feel like there was enough staff to meet resident needs on the night shift.

During an interview conducted on at 6:00 a.m. with Staff A (Unlicensed Medication Technician), Staff A did not feel like there was enough staff to meet the residents' needs on night shift. Staff A stated the facility needed more staff and that while the facility previously had more employees, staffing on each shift had decreased.

During an interview conducted on at 6:38 a.m. with Staff B (Unlicensed Medication Technician), Staff B did not feel like there was not enough staff to meet the residents' needs on night shift.

During an interview conducted on at 12:55 p.m. with Staff H (Caregiver), Staff H did not feel like there was enough staff to meet the residents' needs on night shift. Furthermore, Staff H stated that occurred and were not documented.

During an interview conducted on at 12:12 p.m. with Staff K (Caregiver), Staff K did not feel like there was enough staff to meet the

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A 025	Continued From page 25 residents' needs on night shift. During an interview conducted on at 12:20 p.m. with Staff I (Caregiver), Staff I did not feel like there was enough staff to meet the residents' needs on night shift. During an interview conducted on at 12:24 p.m. with Staff J (Caregiver), Staff J did not feel like there was enough staff to meet the resident's needs on night shift. Staff J stated there were only two caregivers on at night. Furthermore, Staff J stated it was difficult to observe all residents in such a large facility, noting that if staff were assisting with a two-person transfer, both caregivers were off the floor and unavailable to others. During an interview conducted on at 12:30 p.m. with Staff L (Caregiver), Staff L did not feel like there was enough staff to meet the residents' needs on night shift. During an interview conducted on at 10:28 a.m. with the Health and Wellness Director (HWD), the HWD agreed that most occurred at night. During an interview conducted on at 1:21 p.m., with the Administrator, the Administrator stated the facility did not perform a new risk assessment every time a resident . The assessment is conducted only when a resulted in injury. Furthermore, the Administrator stated nothing the facility implemented could 100% prevent . During an interview conducted on at 3:34 p.m. with the Administrator, the Administrator could not provide evidence of the Temporary	A 025		

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A 025	Continued From page 26 Service Plan- Forms or incident forms for Residents #6, #11, #14, #15, #17, #18, #19, # 20, #21 and #22.	A 025		
A 052 SS=G	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication 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	A 052		

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A 052	Continued From page 27 assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents 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	A 052		

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	AL11968323	A. BUILDING: _____ B. WING _____	12/29/2025

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A 052	Continued From page 28 medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident 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	A 052		

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A 052	Continued From page 29 prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the 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 and interview, the facility failed to ensure proper assistance with self-administration of medications for four residents (Resident #1, Resident #2, Resident #3, and Resident #4) of four sampled residents that required assistance with self-administration of medications. The facility's non-compliance placed all residents at risk for potential harm.	A 052		

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A 052	Continued From page 30 Findings included: During a medication pass observation for Resident #1, Resident #2, and Resident #3 with Staff A (unlicensed Medication Technician) conducted on between 5:45 a.m. and 6:00 a.m., Staff A failed to remove the medications from their packaging in the presence of Resident #1, Resident #2, and Resident #3. During a medication pass observation for Resident #4 with Staff B (unlicensed Medication Technician) conducted on at 6:32 a.m., Staff B did not remove the medications from their packaging in front of Resident #4 and did not read the medication names aloud. Staff B proceeded to pour medications into Resident #4's while the resident was lying flat on their in bed. Staff B then poured water into Resident #4's while Resident #4 was still lying down in bed, causing Resident #4 to . Staff B did not provide -over-assistance and did not ensure Resident #4 was in a safe, upright position, placing the resident at risk for , , choking, and injury. During an interview with the Wellness Director, conducted on at 10:40 a.m., the Wellness Director stated that unlicensed Medication Technicians should be reading medications aloud, removing the medications from their packaging in front of residents, and that medication should never be given to a resident that is lying on their in bed. Class II	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records	A 054		

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A 054	Continued From page 31 (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate and updated Medication Observation Records (MORs) for one resident (Resident #1) of nine sampled residents who required assistance with self-administration of medication.	A 054		

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A 054	Continued From page 32 Findings included: During a record review of the MORs for Resident #1 conducted on , it was revealed that there were blanks on multiple days for prescribed medications, with no exceptions noted. In an interview conducted on at 10:40 a.m., the Wellness Director stated there should be no blanks on the MOR. (Photographic evidence obtained.) Class III	A 054		
A 056 SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to	A 056		

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A 056	Continued From page 33 another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled	A 056		

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A 056	Continued From page 34 or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to ensure medications were administered in accordance with physician orders by changing medication administration times without obtaining a physician's order for three residents (Resident #1, Resident #2, and Resident #4) of three residents sampled. This non-compliance placed all residents at risk for potential harm. Findings included:	A 056		

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A 056	Continued From page 35 A review of Resident #1, Resident #2, and Resident #4's Medication Observation Records (MORs), conducted on , revealed that the facility changed scheduled medication administration times for the residents without obtaining a physician's order authorizing the changes. According to the MORs, the changes to medication times occurred on . Medications originally ordered to be given at 6:00 a.m., were rescheduled by facility staff to be administered between the hours of 10:00 p.m. to 6:00 a.m. without documentation of a prescriber's authorization. During an interview with the Wellness Director, conducted on at 10:40 a.m., the Wellness Director stated they changed the times without a doctor's order so it would be easier for staff to pass medications on time. The Wellness Director agreed medication administration times should only be changed with a doctor's order. (Photographic evidence obtained.) Class II	A 056		