

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968435</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/08/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOMERSET COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>34731 CHANCEY RD<br/>ZEPHYRHILLS, FL 33541</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                         | Initial Comments<br><br>A re-licensure survey with Extended Congregate Care and Limited Mental Health in conjunction with a generator monitoring visit was conducted at Somerset Community on . Deficiencies were identified at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 000                                                                                      |                                                                                                                          |                                                        |
| A 010<br>SS=D                                                 | 429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency<br><br>429.26 Appropriateness of placements; examinations of residents.-<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.<br>(b) A facility may admit or retain a resident who requires the use of assistive devices.<br>(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, | A 010                                                                                      |                                                                                                                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

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| A 010                                                         | <p>Continued From page 1</p> <p>additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.</p> <p>(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:</p> <ul style="list-style-type: none"> <li>a. Move, turn, or reposition without total physical assistance;</li> <li>b. Transfer to a chair or wheelchair without total physical assistance; or</li> <li>c. Sit safely in a chair or wheelchair without personal assistance or a physical .</li> </ul> <p>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.</p> <p>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.</p> <p>(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the</p> | A 010                                                                          |                                                                                                                          |                          |                                                        |

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| A 010                                                         | <p>Continued From page 2</p> <p>applicable department.</p> <p>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.</p> <p>59A-36.006</p> <p>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:</p> <p>(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.</p> <p>(b) A resident requiring care of a _____ may be retained provided that:</p> <ol style="list-style-type: none"> <li>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,</li> <li>2. The condition is documented in the resident's</li> </ol> | A 010                                                                          |                                                                                                                          |                          |                                                        |

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

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| A 010                                                         | <p>Continued From page 4</p> <p>holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interviews, the facility failed to maintain an updated Agency for Health Care Administration (AHCA) 1823 Health Assessment Form, following a significant change in condition for one resident (Resident #3) of two sampled residents.</p> <p>Findings included:</p> <p>During a resident record review, conducted on , revealed Resident #3's latest 1823 form was documented as requiring total care for all Activities of Daily Living (ADLs) and was identified as bed bound.</p> <p>During an observation on at 8:00 a.m., Resident #3 was observed in the common living area of the facility, eating breakfast and completing ADLs with assistance.</p> <p>During an interview on at 9:35 a.m., the Nursing Coordinator stated the facility received the current AHCA form 1823 following Resident #3's return from a hospital visit. The Nursing Coordinator further stated Resident #3 did not require total care and was able to complete ADLs with assistance. The Nursing Coordinator also confirmed Resident #3 had been receiving Home Health Care services for , . The Nursing Coordinator acknowledged the AHCA Form 1823 had not been updated following a significant change in the resident's condition.</p> <p>(Photographic evidence obtained)</p> | A 010                                                                                      |                                                                                                                          |                                                        |

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| A 010                                                         | Continued From page 5<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | A 010                                                                                      |                                                                                                                          |                                                        |
| A 162<br>SS=D                                                 | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records<br>must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. ,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of<br>other health insurance ,<br>8. Name, address, and telephone number of next<br>of kin, legal representative, or individual<br>designated by the resident for notification in case<br>of an emergency; and,<br>9. Name, address, and telephone number of the<br>resident's health care practitioner and case<br>manager, if applicable.<br>(b) A copy of the Resident Health Assessment<br>form, AHCA Form 1823 or the health care<br>practitioner's medical examination form described<br>in Rule 59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services,<br>therapeutic diets, , or<br>other services to be provided, supervised, or<br>implemented by the facility that require a health<br>care provider's order.<br>(d) Documentation of a resident's refusal of a<br>therapeutic diet pursuant to Rule 59A-36.012,<br>F.A.C., if applicable.<br>(e) The resident care record described in<br>paragraph 59A-36.007(1)(f), F.A.C.<br>(f) A record that is initiated on admission.<br>Information may be taken from AHCA Form 1823<br>or the resident's health assessment. Residents | A 162                                                                                      |                                                                                                                          |                                                        |

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| A 162                                                         | Continued From page 6<br><br>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.<br>(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 such consent is not included in the resident's contract.<br>(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.<br>(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.<br>(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.<br>(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.<br>(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: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a> . The absence of this form will not be | A 162                                                                                      |                                                                                                                          |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968435</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/08/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOMERSET COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>34731 CHANCEY RD<br/>ZEPHYRHILLS, FL 33541</b>                               |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 162                                                         | <p>Continued From page 7</p> <p>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.</p> <p>(m) Documentation of the . . . of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C.</p> <p>(o) The resident's . . . , DH Form 1896, if applicable.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interviews, the facility failed to maintain current resident</p> | A 162                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968435</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/08/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOMERSET COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>34731 CHANCEY RD<br/>ZEPHYRHILLS, FL 33541</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 162                                                         | <p>Continued From page 8</p> <p>contracts for one resident (Resident #2) of two sampled residents.</p> <p>Findings included:</p> <p>During a resident record review conducted on _____, revealed Resident #2, who was a current resident admitted on _____, did not have a signed contact in the resident file.</p> <p>During an interview on _____ at 9:35 a.m., the Nursing Coordinator stated the facility could not find the contract for Resident #2.</p> <p>Class III</p> | A 162                                                                                      |                                                                                                                          |  |                                                        |