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
	AL11964897	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF DEER CREEK	2403 WEST HILLSBORO BLVD DEERFIELD BEACH, FL 33442

(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
ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

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

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to timely submit their request for approval of the Comprehensive Emergency Management Plan (CEMP) following a change of ownership. The findings included: During an interview on at 11:03 AM the Administrator was asked to provide the facility's current CEMP approval letter or provide all communications and submissions to the Local County Emergency Management Division. At this time, he stated the facility had a change of ownership on . A review of the facility's last CEMP approval letter dated , documented the plan was approved through . As such, the facility was required to submit their Comprehensive Emergency Management Plan (CEMP) within 30 days after the change of ownership. During an interview on at approximately 6:00 PM the Administrator was informed of the findings. No additional documentation was provided. Class III	ZZ830		
ZZ875	430.5025(4 &) / ; Training	ZZ875		

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ZZ875	Continued From page 3 (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	ZZ875		

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ZZ875	Continued From page 4	ZZ875		

employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information,

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ZZ875	Continued From page 5 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	ZZ875		

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ZZ875	Continued From page 6 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to ensure direct care staff had completed required continuing annual education of 4-hour Training (ADRD) for 3 of 4 sampled staff (Staff A, C and D). The findings included: The facility has a Memory Care unit (MCU) with a census of 19 residents at the time of the survey. During an interview on at approximately 9:45 AM the Administrator was informed to provide employee files for Staff A, C	ZZ875		

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ZZ875	Continued From page 7 and D. During an interview on at 1:49 PM the Administrator was asked if the Assisted Living (AL) direct care staff provided care and services to the MCU and he confirmed all staff are cross trained to work on AL and MCU. 1) A review of the personnel file for Staff A (Administrator) with a hire date of revealed Staff A did not have documented evidence of 4 hours of continuing education for Training. The last Training (4-hours) was documented on and . 2) A review of the personnel file for Staff C (Caregiver) with a hire date of revealed Staff C did not have complete evidence of 4 hours of continuing education for 's Training. The last Training was documented as follows: On - 30 minutes training On - 1 hour training On - 1 hour training On - 1 hour video 3) A review of the personnel file for Staff D (Caregiver) with a hire date of revealed Staff D did not have complete evidence of 4 hours of continuing education for 's Training. The last Training was documented as follows: On - 1 hour training On - 30 minutes training On - 1 hour training On - 1 hour video	ZZ875		

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ZZ875	Continued From page 8 During an interview on at approximately 4:30 PM the Administrator was informed of the missing training mentioned above. No additional documentation was provided. Unclassified	ZZ875		

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A 000	Initial Comments AMENDED An unannounced Relicensure with Limited Nursing Services (LNS), Complaint (2024003931) and a Generator Monitoring survey was conducted on - at Celebration Villa Of Deer Creek. The facility had deficiencies identified related to the Relicensure with Limited Nursing Services (LNS) at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (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: (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. (b) A facility may admit or retain a resident who	A 010		

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A 010	Continued From page 1	A 010		

requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, 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.
(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:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
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.
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.

(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

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A 010	Continued From page 2 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 applicable department. (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. 59A-36.006 (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: (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. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care,	A 010		

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A 010	Continued From page 3	A 010		

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,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily

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A 010	Continued From page 4 living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record review and interview, it was determined that, the facility failed to ensure that a Resident's Health Assessment was accurate and reflective of a resident's current diagnosis and care needs, for 1 of 2 resident records reviewed. (Resident #9). It was also determined that the facility failed to reassess a resident upon significant health changes to ensure the resident met the criteria for continued residency and that the facility was capable of meeting the resident care needs. The findings included: Observations on at approximately 8:50 AM of Resident #9, revealed the resident required total assistance with feeding. Resident #9 was observed being fed breakfast by facility staff. Record review of R#9's file revealed an admission date of . Review of Resident #9's Health Assessment revealed the following concerns: a) The Medical History and Diagnoses are not listed on the form. The form listed -10( ) codes instead of actual diagnosis for the resident. b) or Behavioral Status: disoriented at times, , mostly calm, , ;	A 010		

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A 010	Continued From page 5 follows direction although sometimes ; no aggressive behavior, memory issues. c) Special precautions noted as precautions d) Activities of Daily Living noted as total for bathing, , self- care, toileting and assistance with ambulation, eating, and transferring. e) Section C of 1823, the resident needed 24-Hour Nursing or , care. Further record review revealed that the Resident is not enrolled in Hospice Services and has not been reassessed due to health decline or for continued residency. During an interview with ADON on at 3:15 PM, the ADON stated most of the residents in memory care see a psychiatrist, the ADON stated, Resident #9 is currently seeing a psychiatrist, and further stated they always see psychiatrist. The ADON was requested progress notes from the psychiatrist. During an interview with ADON at 3:28 PM, the ADON stated she cannot obtain psychiatrist progress notes as the Resident came from another Assisted Living Facility (ALF) with that 1823. The ADON further stated "We don't re do 1823, when they come from another facility, we just check them." Class III	A 010		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES.	A 031		

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	AL11964897	A. BUILDING: _____ B. WING _____	12/09/2025

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A 031	Continued From page 6 (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to	A 031		

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A 031	Continued From page 7 the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to properly coordinate hospice care and services for 1 of 2 residents reviewed for third party services (Resident #13). The findings included: Record review of Resident #13's AHCA form 1823 dated revealed an initial admission date on and had the following diagnoses listed: Right ankle , Functional Decline, , , , . Further review documented that the resident uses a wheelchair	A 031		

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A 031	Continued From page 8 with assistance, and requires nursing, physical and , . . However, this 1823 form did not reflect that Resident #13 was receiving hospice services. Review of the Physician's Orders showed that Resident #13 had no order for admission into the hospice care services. Record review of Resident #13's paper chart and electronic chart revealed no hospice communication notes. In addition, there was no contract with the hospice service on file and therefore, unable to determine when Resident #13 started receiving hospice care. On at 12:36 PM an interview was conducted with the hospice nurse. She stated she communicates with the nurses verbally, gives them the physician's orders and she faxes the orders to the pharmacy if there are any changes. She stated the hospice binder is kept in the nurses' office, and it contains all the forms and the interdisciplinary care plans. The hospice nurse was asked for Resident #13's communication and paperwork. She was unable to show any documentation for Resident #13 and stated that she was supposed to print out the assessments. She also stated that the facility does not have access to the hospice system to view the communication notes or assessments. Then, she stated she will have to print them and put them in the facility's binder. An interview was conducted on at 3:29 PM with Assistant Director of Nursing (ADON). She stated that all hospice notes and orders are kept in the resident's paper chart. At this time, a side-by-side review of Resident #13's paper chart (which contained a hospice folder) was	A 031		

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A 031	Continued From page 9 conducted with the ADON in which it was pointed out that there were no notes, orders, or contract for services between the resident and hospice company. In addition, the 1823 form was not updated to reflect that Resident #13 was under hospice care and the ( ) form was not signed by the physician. She then stated she will bring the hospice binder because some of the documentation is stored there. She reviewed the hospice binder and again found no documentation for Resident #13 including the contract. The ADON then stated that the hospice nurse usually communicates verbally with the floor nurse, and then the floor nurse adds a progress note on the computer (No progress notes were found for hospice on the computer). On at 4:52 PM a phone interview was conducted with Resident #13's daughter, who stated her mom has been under hospice services for a few months now and that Resident #13 has an order for ( ). Class III	A 031		
A 056	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:	A 056		

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A 056	Continued From page 10 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 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	A 056		

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A 056	Continued From page 11 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 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 observation, record review and interview, it was determined that the facility failed to ensure that Staff assisting residents with Self-Administered Medications, follow the physician orders as shown on the medication	A 056		

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A 056	Continued From page 12 label for 1 of 5 sampled residents (Resident #12). The findings included: An observation on at approximately 9:20 AM during medication pass Staff # B (Medication Technician) was observed assisting Resident #12 with assistance of self-administration of medication for medication 50 mcg. Further review of the medication label on the medication revealed the following parameters and directions: 50 mcg, take 1 tablet by every morning on an empty . During an interview on at 9:23 AM surveyor asked Resident #12 if he had breakfast. At this time resident stated yes. During an interview on at approximately 9:25 AM Staff B was asked why she was not following medication parameters (direction of use) Staff stated she was not aware of the direction of use at the time of medication pass. During an interview on at approximately 2:30 PM surveyor met with Staff F (Assistant Director of Nursing) and she was informed of the findings mentioned above. During an interview on at approximately 6:30 PM surveyor met with the Administrator and he was informed of the concerns regarding unlicensed personnel (Medication Technician) not following medication direction of use at the time of medication pass. He acknowledged the findings.	A 056		

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A 056	Continued From page 13 Class III	A 056		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice	A 081		

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A 081	Continued From page 14 training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of	A 081		

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A 081	Continued From page 15 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

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A 081	Continued From page 16 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure direct care staff completed the required training requirements within the required timefram (30 days of hire), for 3 of 4 sampled staff (Staff B, C D) The findings included: During an interview on at approximately 9:45 AM the Administrator was informed to provide employee files for Staff B, C and D. 1) A review of the personnel file for Staff B (Medication Technician) with a hire date of . Staff B did not have the following training in her file. a) Preservice Orientation. b) Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures and Incident Reporting Training. 2) A review of the personnel file for Staff C	A 081		

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A 081	Continued From page 17 (Caregiver) with a hire date of . Staff C did not have the following training in her file. a) Preservice Orientation. b) Control (1-hour) Training - review revealed 45 minutes (15 minutes, 15 minutes, and 15 minutes). c) ADL and Behavioral Needs Training. d) Elopement Response Training. e) Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures and Incident Reporting Training. 3) A review of the personnel file for Staff D (Caregiver) with a hire date of . Staff D did not have the following training in her file. a) Preservice Orientation. During an interview on at approximately 4:30 PM the Administrator was informed of the missing training mentioned above. No additional documentation was provided. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4) . / . (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the	A 082		

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A 082	Continued From page 18 section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure direct care staff obtained required training for (/) for 1 of 4 sampled staff (Staff C) The findings included: During an interview on at approximately 9:45 AM the Administrator was informed to provide employee file for Staff C. 2) A review of the personnel file for Staff C (Caregiver) with a hire date of . Staff C did not have / training in her file. During an interview on at approximately 4:30 PM the Administrator was informed of the missing training mentioned above. No additional documentation was provided. Class III	A 082		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in	A 090		

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A 090	Continued From page 19 resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure direct care staff had training for ( ) for 1of 4 sampled staff (Staff C). The findings included: During an interview on at approximately 9:45 AM the Administrator was informed to provide employee file for Staff C. 2) A review of the personnel file for Staff C (Caregiver) with a hire date of . Staff C did not have training in her file. During an interview on at approximately 4:30 PM the Administrator was informed of the missing training mentioned above. No additional documentation was provided. Class III	A 090		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

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	AL11964897	A. BUILDING: _____ B. WING _____	12/09/2025

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A 152	Continued From page 20 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on interview, record review and	A 152		

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A 152	Continued From page 21 observations the facility failed to provide a safe, clean and decent living environment free of safety hazards for residents that reside at the facility. The findings included: During a tour conducted between and between 9:30 AM and 5:00 PM, the surveyors observed the following physical plant concerns (Photographic evidence obtained). During an interview on at approximately 9:45 AM the Administrator was informed to provide a copy of the Department of Health (DOH) report(s) most recent inspection(s). Record review of the facility's DOH inspection report titled Food Establishment Inspection Report dated documented as follows: The facility operating without required Food Hygiene sanitation certificate/permit. Apply for new Food Hygiene sanitation certificate by . 1.First Floor East - Memory Care unit a) Common area (hallway) throughout the second floor revealed dirty carpet with small and large stains. b) # revealed that the Packaged Air Conditioner (PTAC) unit had rotten wood at the bottom (unit base) and debris (wood like pieces) on the floor under the unit. Further observation revealed baseboard underneath the unit had a visible hole. Furthermore, observations revealed resident's closet ceiling had cracks / separation from the closet wall and ceiling. The closet ceiling had visible brown stains. c) Library ceiling had small black stains (near light	A 152		

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A 152	Continued From page 22 fixture) and Air Conditioning (A/C) vent had large brown and black mold like stains around it. d) Window floral valance (above PTAC) had a large brown stain and wall below window sill was dirty. e) Double glass door: with exit to the patio, where residents congregate for activities revealed a long cable that ran from the top to the mid-section center of the door, had a cable hanging loose with exposed wires (approximately 7 inches long) right below the push handle (left handle). 2. First Floor West - Memory Care unit: Common area (hallway) throughout the second floor revealed dirty carpet with small and large stains. a) Big Dining room: Approximately 4 Air Conditioning (A/C) vents, that had significant accumulation of filth, black mold like stains around it and dirt buildup. The ceiling surrounding the chandelier had a large brown stain. Further observations revealed that the east entrance of the dining room ceiling had a very large brown stain (upon entrance to the dining room). b) Common area Bathroom (near big dining room entrance) bathroom door was jammed and unfinished construction wall work. c) Ceiling near the Nursing Office: observation revealed ceiling had cracks and visible holes and A/C vent was filthy, grimy residue and dirt buildup. d) Ceiling A/C vent (hallway) near the Activity	A 152		

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A 152	Continued From page 23 room was filthy with dirty buildup. e) , resident's bathroom vanity wall behind the faucet revealed unfished drywall work. Further observations revealed the cabinet under the sink (resident's kitchen) was damaged; the compressed wood was , and the white doors were splitting. f)) Laundry room revealed the following: corner ceiling (above dryer) had large brown and black mold like stains. The Wall (around the dryer) had large chunks of paint peeling and bubbling. Large water puddle was observed on the floor. 3. First Floor - Kitchen A significant accumulation of water was observed originating from the baseboard at the kitchen entrance, pooling in that area and extending onto the dining room floor. 4. Small Dining room - Assisted Living (First Floor): revealed approximately 5 Air Conditioning (A/C) vents that had significant accumulation of filthy, grimy residue and dirt buildup, the ceiling and crown molding had a lot of small and large dark brown and black spots throughout the whole dining room ceiling. Further observations revealed large chunks of paint were observed peeling from crown molding on the ceiling near the chandelier. Furthermore, observations revealed a large puddle of water (near the kitchen entrance) on the floor under the dining table. 5. Second Floor East - Memory Care unit	A 152		

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A 152	Continued From page 24 a) Common area (hallway) throughout the second floor revealed dirty carpet with small and large stains. b) Observations of the common area (hallway) revealed a Packaged Air Conditioner (PTAC) unit near , had exposed cables with wires (PTAC located on the east side of the hallway below the window) c) Observations of the common area (hallway) near revealed wall paint around the PTAC unit was bubbled. Further observations revealed the common area was a storage for box spring and mattress. 6. Second Floor West - Memory Care unit a) Observation of the kitchen (prep kitchen) revealed as follows: Filthy white cabinets, with grime and food spills. Light fixture was missing 3 working light bulbs (poor lighting). Walls were dirty and grimy. Floor was filthy. Portable A/C unit on the wall, was not in a working condition (temperature was registered at 82 degrees Fahrenheit (82 °F) with surveyor's thermometer). Observations of the refrigerator interior revealed accumulation of food spills, grime on the shelves, walls and racks. b) was missing closet door c) Activity room ceiling had large brown stains. 7. Third Floor West (room's 308 - 325)	A 152		

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A 152	Continued From page 25 a) Common area (hallway) throughout the second floor revealed dirty carpet with small and large stains. b) Window (above PTAC unit) in the common area / hallway near , revealed that the window frame paint was peeling and bubbling. c) A/C vent in the common area, near was filthy with large brown stains around the vent. d) Light fixture in the center of the ceiling near the elevator was not in working condition. e) A/C vent in the common area (near the elevator) filthy and grimy. f) Ceiling near the elevator showed large brown stains, cracks and paint that was peeling and bubbling. 8. Third Floor East Ceiling area near the elevator revealed paint that was peeling and bubbling. A/C vent on the ceiling near the elevator was filthy and grimy. Light fixture near the elevator revealed crack in the drywall / ceiling. PTAC unit near revealed paint that was peeling and bubbling around it. 9. Fourth Floor West (room's 400 - 409) a) Common area (hallway) throughout the second floor revealed dirty carpet with small and large stains. b) Ceiling A/C vent in the common area / hallway	A 152		

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A 152	Continued From page 26 near was filthy with dirt buildup. c) Dirty walls near in the common area /hallway. d) Fourth Floor East Ceiling near the elevator revealed a hole of approximately 12 inches by 12 inches (12" x 12") and paint peeling and bubbling in its surroundings. Ceiling area near the elevator revealed large brown stains, paint peeling and bubbling. Ligh fixture near the elevator was not in working condition. Fire sprinkler near the ceiling revealed cracks on the ceiling. Common area between room's 414 and 416 reveal cracked wall and crown molding on the ceiling. During an interview on at approximately 5:35 PM a team of surveyors met with the Administrator and he was informed of the concerns mentioned above. At this time the Administrator acknowledged the findings and confirmed the facility has problems with the roof and other repairs are needed. No additional documentation and/or invoices were provided during the survey to support repairs. Class III	A 152		
AN277	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the	AN277		

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AN277	Continued From page 27 admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to properly maintain Limited Nursing Services (LNS) documentation and failed to ensure staff were educated on LNS standards for 2 of 2 residents reviewed for LNS (Resident #12 and Resident #13). The findings included: Review of the facility's policy titled, "Limited Nursing Services (LNS)," dated , included	AN277		

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AN277	Continued From page 28 the following: Policy Overview: Limited nursing service plan will be developed and reviewed with input from the resident and his/her legal representative and the community's interdisciplinary team. Policy Detail: 2. The Health and Wellness Director (HWD)/Nurse designee will notify the resident, his/her legal representative, and the physician/primary care provider of the additional needs of services. Upon receipt of the physician/primary care provider's order, the resident's name and other pertinent information will be entered on the LNS log. Record review for Resident #12 revealed that the resident was admitted to the facility and to Limited Nursing Services (LNS) on with diagnoses that included: Retention of . Further review of Resident #12's chart revealed there was no LNS care plan developed and no physician's order to receive nursing services for care. In addition, there were no monthly nursing assessments documented for Resident #12. Record review for Resident #13 revealed that the resident was admitted to the facility on and on admitted to the LNS program with diagnosis of Retention of and . Further review of Resident #13's chart revealed there was no LNS care plan developed and no physician's order for care. In addition, monthly nursing assessments were conducted for Resident #13 from with the last nursing assessment was on .	AN277		

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AN277	Continued From page 29 During an interview conducted on at 9:50 AM with Resident #12, who stated he transferred to this facility because they had the LNS licensure and with his , they can provide the care he needs. He stated he receives , care from the staff and feels comfortable knowing if he needs assistance the facility can provide the care and not send him out to the hospital. During an interview conducted on at 10:10 AM with the Assistant Director of Nursing (ADON), who stated that the LNS nurse was the Director of Nursing (DON) and her last day at the facility was . She stated she is not sure if the facility has LNS residents because the two residents (Resident #12 and #13) listed on the LNS log are under the care of their urologists. She confirmed that both residents have , and nurses document in the LNS progress notes daily about the status of the , . However, she stated since the residents are not part of the LNS, they do not require monthly nursing assessments. The ADON acknowledged that since the DON was the one taking care of the LNS, she doesn't know too much about LNS. During an interview conducted on at 1:14 PM with Staff N, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3 months. Staff N was asked if she knew what LNS consisted of. She appeared and was unable to answer. She then confirmed that she has not received any training or education on LNS. Review of staff records, including the ADON and Staff N, revealed no LNS training for nursing staff.	AN277		

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AN277	Continued From page 30 Class III	AN277		