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
	AL11970609	A. BUILDING: _____ B. WING _____	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CORAL GABLES	1000 PONCE DE LEON BLVD CORAL GABLES, FL 33134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (#2025016614 and #2025014210) was conducted at Sunrise of Coral Gables on . Deficiencies were found at the time of survey.	A 000		
A 010 SS=H	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 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	A 010		

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A 010	Continued From page 1 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 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.	A 010		

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A 010	Continued From page 2 (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, 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	A 010		

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A 010	Continued From page 3 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 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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure five out of thirty-one sampled residents (#7, #6, #8, #12 and #9) met the continued residency criteria in the Assisted Living Facility. Findings as follow: On at 7:12 a.m. observed Resident #7 asleep in a hospital bed with half bed rails and floor mats. A review of Resident #7's Health Assessment dated revealed the resident was diagnosed with , acute , injury, , hypernatremia, acute , , , and severe protein calorie . It also stated that Resident #7 required assistance with ambulation, bathing, , eating, grooming, toileting, and transferring. On at 7:12 a.m. Staff D stated Resident #7 has been at the facility since in the same condition. When asked, whether Resident #7 ambulated Staff D answered the resident did not walk and it required to be fed and to be assisted to sit in the wheelchair by two staff. On at 7:15 AM Resident #6 was observed lying in bed. A review of Resident #6 Health Assessment dated showed a Diagnosis of , , , Generalized , . It also documented the resident was not bedbound and he needed assistance	A 010		

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A 010	Continued From page 5 with self administration of medications. The Assessment did not document the assistance resident needed with self- administration of medications. On at 7:16 AM Staff D stated Resident #6 had been living in facility since and always showing the same non ambulatory condition. On at 7:18 AM Resident #8 was observed in bed. A review of Resident # 8's Assessment dated showed a Diagnoses of Fibrilation, 's Cance and showed the resident needed assistance with all the activities of daily living and with self administration of medications. On at 7:20 AM observed Resident #12 in bed. A review of Resident #12 Health Assessment dated showed the resident was diagnosed with prostatic hyperplasia with obstruction and, with . It also revealed that the resident needed assistance with ambulation, bathing, eating, grooming, toileting, and transferring and needed medication administration. On at 7:26 AM Resident #9 was observed in bed. A review of Resident #9's Assessment showed the resident was diagnosed with	A 010		

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A 010	Continued From page 6 , , and needed assistance with the activities of daily living and self administration of medications. On at 7:30 AM Staff D stated Residents #8, #12 and #9 were not ambulatory. A review of Resident #7, #6 , #8, #9 and #12's records showed there were not a doctor's order requesting Hospice evaluation for the residents to be placed under their services. and a review of Residents #7, #6, #8, #9 and #12 progress notes showed there were not documented the Doctor and/or family had been contacted regarding the residents evaluation and admission to Hospice care. A review of the facility's residents' assessment and evaluation policy worded: "It is he policy of the community to assess/evaluate residents to determine care and service needs, determine that the community can meet the resident's care and service needs and establish an individualized service plan." A review of the facility's Residency Criteria Policy revealed in Section 5 "If a current resident progresses to the point where their assessed care and the service needs cannot be met in the community, the Executive Director and Resident Care Director coordinate a discharge plan with the resident, family, and physician. On at 11:53 a.m. when asked the executive director what was the process of assessing residents he stated that Resident #7 needed to stand to pivot for admission in the facility. When asked why Resident #7 hasn't received hospice services he voiced that he placed a hospice order and progress note	A 010		

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A 010	Continued From page 7 weeks ago regarding that matter and when asked why the facility didn't provide a 45-days' notice of termination of residency the Executive Director stated he waited for Resident #7 family to meet with hospice but it had been unsuccessful. The executive Director did not explain reason why non ambulatory residents #6, #8, #9 and #12 were not under the care of Hospice and continued living in facility without meeting the assisted living facility residency criteria. Class III	A 010		
A 025 SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards.	A 025		

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A 025	Continued From page 8 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate supervision to ensure awareness of the general health, safety, physical and emotional well-being for two out of thirty-one sampled residents (Resident #3, Resident #13) after Resident #3 eloped from the facility. Also, Resident #13	A 025		

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A 025	Continued From page 9 sustained multiple at the facility in which resulted in injuries such as injuries including nosebleeds. Findings: An observation on at 7:49AM, showed Resident # 3 walked and forth in the Memory Care Unit hallway and continuously pressed the access code keypad to exit the Memory Care Unit floor. In an interview on at 2:46PM, Resident #3's mother stated that prior to admission, Resident #3 always and eloped from the previous apartment and was in a local hospital. When Resident #3 first arrived at the facility on , she was on the sixth floor and after the resident eloped from the facility on , she was moved to the 4th. floor - Memory Care Unit. Resident #3's mother voiced that the resident's photo identification card is in her wallet attached to a purse. Resident #3's mother stated, "The facility interviewed her and me at the hospital to do an initial evaluation for admission after the she eloped from her apartment." A review of the facility's Residency Criteria Policy revealed "Conditions that make a resident ineligible for move-in may include. Section G exhibiting behaviors that pose a danger to self or others." A review of the facility's Missing Resident Policy revealed in Section 11 "The Executive Director (ED) and Resident Care Director (RCD)/designee shall evaluate the appropriateness of the resident's neighborhood, including discussing the potential need for transfer and the temporary	A 025		

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A 025	Continued From page 10 interventions for oversight with responsible parties." An observation on at 7:23AM, showed Resident #13 asleep in bed with a bandage gauze on the forehead area. During an interview on at 7:23AM, Staff D (Certified Nursing Assistant) stated Resident #13 can walk but cannot do anything else. Staff D also stated that she had to feed and dress Resident #13. In an interview on at 7:24 AM, Staff D stated Resident #13 two days ago. Staff D didn't know how Resident #13 but remembered previously Resident #13 was walking in the afternoon and bumped his into the wall and went to the hospital. Staff D stated, "Resident #13 does not like to use the walker or wheelchair." An observation on at 7:39AM, showed Resident #13 woke up from his bed, opened his bedroom door and attempted to walk in the hallway. Further observation found that Resident #13 was visibly unsteady on his while he walked without assistance. Staff H (Certified Nursing Assistant) eventually arrived and held Resident #13 and walked him slowly to his bedroom and into the bathroom. In an interview on at 7:40AM, when asked why she held Resident #13's while he walked, Staff H stated, "I do not want the resident to ." A Review of Resident #13's progress notes completed on , revealed "At 05:02AM,	A 025		

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A 025	Continued From page 11	A 025		

received a phone call from the residents' son reporting that Resident #13 was walking inside his room. Upon going upstairs to assess, the case managers were already present in the room, and the resident was found on the floor. Resident was positioned in a semi sitting posture against the wall, with a rollator walker located between his body and the wall. Resident # 13 was assisted to a standing position and then safely transferred to bed. A complete assessment was performed. On examination, noted a scratch to the mid-center and two additional on the left lateral side. No active noted. No complaints of at that time. Resident #13 was not in acute distress. Resident #13 placed in bed in a comfortable position. Safety measures implemented. The Primary Care Physician was notified for evaluation, and an was requested for further assessment. Will continue to monitor."

A review of Resident #13's progress notes dated showed " was unwitnessed in resident's room on12/03/2025 5:07AM. Resident #13 was unable to describe the event and how they felt just prior to falling."

A review of Resident #'s 13 progress notes dated showed "During night medication pass, Care Manager called his nurse reporting the resident had a . Upon arrival at the hallway, resident was found on the floor down in a prone position. Active noted and a visible pump present on the forehead area. Vital signs obtained : , , : , temperature: 97.4 Fahrenheit; , even and non-labored and no loss of reported at time of assessment. Resident #13 was unable to recall the event. controlled with gentle

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A 025	Continued From page 12 pressure. No other visible injuries were noted. 911 was immediately called for further evaluation due to injury and active . Resident #13 was kept in place and not moved until paramedics arrived to avoid potential injury. Paramedics arrived on scene, report given, and Resident #13 was transported to the hospital for further assessment. Primary Care Physician and family member (spouse) with phone number were notified." A review of Resident #13's progress notes dated showed "At 20:50 hours, 911 ambulance arrived at the facility in response to the call made for Resident #13. I provided a full handoff report, including the residents' condition, assessment findings, vital signs, and events prior to their arrival. Resident was assessed by (Emergency Medical Services) and then safely transferred to the stretcher using proper technique. Resident was transported to Doctor's hospital for further evaluation and treatment. Primary Care Physician and family members were notified of ambulance arrival and transfer. Documentation completed per facility protocol." Class II	A 025		
A 030 SS=F	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the	A 030		

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A 030	Continued From page 13 admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions;	A 030		

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	AL11970609	A. BUILDING: _____ B. WING _____	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CORAL GABLES	1000 PONCE DE LEON BLVD CORAL GABLES, FL 33134

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A 030	Continued From page 14	A 030		

8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and

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A 030	Continued From page 15 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , ,	A 030		

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A 030	Continued From page 16 for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.	A 030		

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A 030	Continued From page 17 (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . or . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the	A 030		

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A 030	Continued From page 18 facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to arrange hospice services for 6 out of 30 sampled residents (Residents #6,7,8,9,10 and 12). Findings: Review of the facility's policy statement on assessing and evaluating residents showed, "It is the policy of the community to assess/evaluate residents to determine care and service needs, determine that the community can meet the resident's care and service needs an establish an individualized service plan. On at 12:01pm regarding Residents #6,7,8,9,10 and 12 were non ambulatory who were non-ambulatory, the Administrator stated ."Well, when they come here we do the assessment, and the Administrative Assistant and I go out to the home or facility to do an assessment on them as well." She stated, "Well, when they come here, we do the assessment, and [the Administrative Assistant] and I go out to the home or facility to do an assessment on them as well." The Administrator further stated that the residents met criteria to be admitted.	A 030		

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A 030	Continued From page 19 On at 12:18PM during the exit conference, the Administrator when informed that people need to meet criteria when they are admitted and the duration of their stay in the facility. And if somebody is not enrolled in hospice care and they are not ambulatory; they do not meet criteria; the Administrator responded , "there are two that I know that are enrolled in Hospice" On at 7AM during rounds, Resident #7 was observed in her room laying on her left side on a hospital bed with rails. Further observation at at 7:14AM revealed the bed rails in the up position, and mats on the floor. Resident #7 did not walk and required total assistance from the staff. On at 7AM, Staff D stated that Resident #7 required total care with Activities of Daily Living (ADL). On at 12:10PM, the Administrator stated that he discussed hospice services with the daughter of Resident #7 twice. On at 12:10 pm The Administrator stated, " There is a hospice order. I made the referral twice, but she is not yet enrolled in hospice care." On at 12:12 PM, thr Administrator responded that Resident #7's family asked her to 'give her a chance, give her a chance, she's going to be alright, she just needs a few days to get herself together. ' A review of progress notes of Resident #7, revealed a note written on by a nurse that stated that Resident #7 had no changes in	A 030		

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A 030	Continued From page 20 condition. Resident and physical status fluctuates. Multiple conversations regarding hospice transition with primary caregiver, however, she still in denial. A review of Resident #7 progress note dated revealed that the resident had decreased range of motion and of the extremities present due to previous (accident). The resident was non-ambulatory, and required assistance for mobility. Observation of Resident #6 on at 7:15am revealed that the resident was non ambulatory and required assistance with ADL.non-ambulatory. A review of Resident #6 health assessment dated revealed that the section on activities of daily living was not completed. A review of Resident #8 health assessment dated revealed that Resident #8 needed assistance with all activities of daily living; Observation of Resident #9 on at 7:16AM, revealed that the resident had been at the facility for two weeks and was non-ambulatory. A review of Resident 9's health assessment dated revealed that Resident #9 needed assistance with all ADL. On at 7:16AM resident #10 was observed in bed . Resident #10 was non-ambulatory. On at 743AM, Resident #12 was	A 030		

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A 030	Continued From page 21 observed laying in the bed in an upright position with the of the bed elevated. The bed was in a low lying position close to the ground. He was dressed in a long sleeved shirt and was wearing briefs His were bent and he was trying to remove _/ cushions of , ... He responded to verbal greeting. A _/ drainage bag was observed handing at the bedside seated in a basin. On at 12:14PM, When interviewed about Resident #12, the Administrator stated that the resident started declining about two weeks earlier. The Administrator stated that on the progress notes from three weeks earlier, he'd discussed hospice with the family, and the family was proceeding with the process as planned and he was waiting for the family to meet with hospice. Class III	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary	A 032		

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A 032	Continued From page 22 emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to	A 032		

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A 032	Continued From page 23 subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an assessment for one out of 13 sample residents (Resident #3) for risk of elopement after resident eloped from facility. Resident #3 eloped and was missing for several hours when the facility failed to know the resident's whereabouts who was found 6 blocks away from the facility. The facility also failed to ensure the resident who eloped (Resident #3) had an individualized plan of care and it failed to ensure the resident had an identification that included the name, address and telephone number. Findings as follow: A review of the facility elopement policies showed it was the facility's policy to provide a safe resident environmet to reduce the incidence of missing resident and elopement events and to promote resident safety. Review of the Incident report submitted on showed Resident #3 eloped from facility on . The care manager visited the resident's apartment during lunchtime and the resident was not in her apartment. The care manager notified the Resident Care Director (RCD) and Executive Director (ED) who started the search, The resident was found within 18 minutes of initiating the search and, 6 blocks	A 032		

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A 032	Continued From page 24 away from the facility.The resident was returned Plans were made for the resident's transfer to a secured neighborhood. , , evaluation recommended. A review of the Admission and Discharge record showed Resident #3 was admitted to facility on . A review of Resident #3's Assesment dated showed a diagnosis of , , , , , hard of hearing. Resident was alert and oriented times 3 and she needed safety and precautions. Resident was independent with ambulation, eaating, toileting and transferring and needed supervision bathing, , and self care and assistance with self administration of medications. The resident was not under elopement risk. Further review showed there was not a Health assessment conducted after resident elopement occured on . On between 6:40 and 8:30 AM observed Resident #3 on the Memory Care unit (3rd floor) ambulating by herself and forth on the hall and pressing the keys of the electronic exit door lock without supervision. It was also observed the resident was not carrying any identification with her name, address and telephone number. The resident was not wearing the calling cord. On at 8:12 AM Resident #3 interviewed stated she did have identification and a calling cord but she did not use it, they were in her room. On at 2:26 PM Resident #3's mother interviewed stated "my daughter eloped and she	A 032		

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A 032	Continued From page 25 was previously adding, she was notified that Resident #3 was trying to exit the 3rd. floor by using the codes on the exit keypad. When asked if Resident #3 had an identification she stated "Yes, in her wallet". The Admministrator interviewed stated Resident #3 was assesed by the nurse when returned to facility but she was not reassesed by her primary physician. When asked why Resident #3 had no ID with her he stated Floor #3 had doors locked and there is needed a code to open it. Class III	A 032		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if	A 055		

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A 055	Continued From page 26 kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from	A 055		

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	AL11970609	A. BUILDING: _____ B. WING _____	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CORAL GABLES	1000 PONCE DE LEON BLVD CORAL GABLES, FL 33134

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A 055	Continued From page 27 medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the medications were locked. Findings as follow: On at 7:08 AM it was observed in (Resident#5) , and silver sulfaziadine creams on the table stand and there were also observed detergent bottles in the bathroom cabinet under the sink. At 7:12 AM it was observed cream in the bathroom of (Resident #11).	A 055		

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A 055	Continued From page 28 On at 7:15 AM when doing the facility tour together with Staff B it was observed in # (Resident #14) over the night stand and over the kitchenette counter different types of over the counter , creams and, in one of the kitchenette cabinets there were a cream, Alka- box, an , , , solution 32 FL OZ bottle together with laundry detergent Tide simply all in one bottle, a cleaning bottle containing CLOROX and, 2 containers of Frosted Flakes cereal. In the bathroom's cabinet was seen , , cream and an , , 3% bottle. On at 7:20 AM Staff B stated "We always advise residents they cannot have unlocked medications but [Resident #14's] daughter brought the resident all those medications." On at 12:30 PM when the Administrator was informed about unlocked medications found, he acknowledged it. Class III	A 055		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond	A 165		

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A 165	Continued From page 29 quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results	A 165		

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A 165	Continued From page 30 of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section.	A 165		

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A 165	Continued From page 31 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an incident report within 1 day of the incident occurring. The facility also failed to file A follow-up incident report for 1 out of 31 sampled residents. (Resident#13) Findings include: 1) A review of the Resident#13 progress notes dated at 8:30pm showed an insert stating "during the night medication pass, Care Manager called this nurse reporting that the resident had . Upon arrival to the hallway, resident was found on the floor in prone position with his down. The resident there was a visible pump on the forehead. controlled with gentle pressure. No other visible injuries are noted. 911 was immediately called for further evaluation due to injury and active . Resident #13 was kept in place and not moved until paramedics arrived to avoid potential injury. Paramedics arrived and the resident was transported to the hospital for further assessment. 2) On at 05:02 pm, the facility received a phone call from the Resident# 13 son reporting that the resident was walking inside his room. Upon going upstairs to assist the resident, the resident was found on the floor. Resident was positioned in a semi-sitting posture against the wall, with a rollator walker located between his body and the wall. Resident #13 was assisted to standing and then safely transferred to	A 165		

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A 165	Continued From page 32 bed. A complete assessment was performed. On examination, noted a scratch to the mid-center and two additional on the left lateral side. No active , noted. No complaints of any , at the time. Resident#13 was in no acute distress. Resident#13 was placed in bed in a comfortable position. Safety measures implemented. Medical Doctor was notified for evaluation, and an , was requested for further assessment. Will continue to monitor." A review of the state Adverse Incident Reporting System (AIRS) system on revealed the facility did not file an incident report for the indicated on , or . Further review of the AIRS reporting system revealed no 15-day follow-up report on either of the incidents, in which on of the incidents resulted in the resident being injured and receiving medical care from the Hospital. During an interview on at the Administrator was asked did he have access to the AIRS system on the day that the facility opened for business? The Administrator stated "No the only person who had access was the prior Administrator, when they left I went to report it, I couldn't report it then I called AHCA (The Agency for Health Care Administration), I and I was granted access. I reported as soon as they gave me access. " Class III	A 165		
A 190 SS=D	59A-36.023( ) & (3)(b); 429.14( ) Administrative Enforcement 59A-36.023( ) & (3)(b) FAC Facility staff must cooperate with agency	A 190		

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A 190	Continued From page 33 personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards	A 190		

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A 190	Continued From page 34 described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 58A-5.0181, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 58A-5.021, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 58A-5.0182, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 58A-5.0182, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for , , and transportation to , , ; 5. Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 58A-5.019, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 58A-5.020, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 58A-5.029, F.A.C., relating to mental health residents' community support living plan; 9. Section 429.07, F.S., and Rule 58A-5.030, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 58A-5.031, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the	A 190		

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A 190	Continued From page 35 abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to fire safety, that threaten the life or safety of a resident; 2. Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III	A 190		

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A 190	Continued From page 36 deficiency directly related to dietary standards as established in Rule 58A-5.020, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial on-site consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's	A 190		

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A 190	Continued From page 37 expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed provide staff records, medical records, staff training and their policy and procedures for response to elopement for 1 of the 12 sampled Staff (Staff D) and the health assessments for 12 of the 31sampled residents. (Residents #1, # 2, # 3, #4, #5, #4, #5, # 6, # 7, #8, #9, # 10, #11,#12, #13, #30). Findings include: During and interview on at 9:20am a request was made for the health assessment of the non-ambulatory residents (Residents #1, # 2, # 3, #4, #5, #4, #5, # 6, # 7, #8, #9, # 10, #11,#12, #13, #30). At 9:43am The Administrator provided the Agency Personnel with documents titled "Resident's Evaluation Form's". During an interview on at 10:02am the Administrator stated the records are all electronic and they are trying to print the documents out but the printer is slow. A record review of the Staff D personnel file on at 8:50am found no documentation on Elopement Training, Control, /First Aid, Behavior Training and Reporting Major Incidents. During an interview on at 9:25am the Administrator stated all the staff files are electronic, they have a program that the employees go on and complete the trainings and he can go online to print them out. Additional	A 190		

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A 190	Continued From page 38 request was made for training, however the Administrator failed to provide the requested documents. Class III	A 190		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be	A 077		

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A 077	Continued From page 39 under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:	A 077		

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A 077	Continued From page 40 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at:	A 077		

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A 077	Continued From page 41 http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to assure to be under the supervision of an administrator who completed the CORE competency test and who were responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. In addition, the facility owners failed to notify the Agency Central Office within 10 days of a change in facility administrator causing the facility operated without an Administrator for more than 120 days. Findings as follow: Review of the Facility Finder database showed Staff L was the facility's administrator. Review of the Facility's roster in the background screening database showed the Administrator had been hired on and terminated in its position on . On at 9:30 AM Staff A presented himself as the facility Administrator. He added Staff L had left the Administration position months ago and he was promoted to it. Review of the Facility's roster in the Background screening database showed Staff A was hired on as staff. Review of Facility records showed there was not any document showing Staff A had been appointed as the facilty Administrator and the change of Administrator	A 077		

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A 077	Continued From page 42 request had been sent to the Agency Further review of Staff A's record showed there was not documentation staff approved the CORE competency test. Class III	A 077		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not	A 078		

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A 078	Continued From page 43 constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility ␣ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two out of eleven of staff sampled (Staff B and Staff C) were qualified to perform their assigned duties consistent with their	A 078		

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A 078	Continued From page 44 level of training and experience. Findings: In an interview on at 7:02AM, Staff C was asked about the , , ( ) procedure, Staff C stated "When I see a patient that was not responding, I would tell a co-worker to call 911, start by giving 15 , to 1 breathe, if I get tired, another co-worker with continue with until 911 arrives. In an interview on at 7:20AM, Staff B was asked what was needed to perform if a resident needs it, she stated, "I call the resident by name, check , , place the person on the floor, give 13 , followed by 2 to , and when the resident reacts, I will stop ". In an interview on at12:33PM, the Administrator was informed that staff were unfamiliar with the process or able to give details how to respond if residents were unresponsive and needed . No response from the Administrator. In an interview on at 12:27PM, The Administrator was advised that only 2 staff members on the fourth floor and 7 residents that need assistance with ambulation and most of them are bed bound with 2 hospice residents and with 2 staff members on that floor. No response from the Administrator. Review of Staff B's personnel record showed a First Aid / , , ( ) / automated external defibrillator ( ) dated , expired on . (photographic	A 078		

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A 078	Continued From page 45 evidence obtained) Review of Staff C's personnel recordshowed a First Aid / , , ( ) / automated external defibrillator ( ) dated , expired on . (photographic evidence obtained) Class III	A 078		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for	A 079		

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A 079	Continued From page 46	A 079		

purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the

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A 079	Continued From page 47	A 079		

minimum staffing hours requirement.
8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility

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A 079	Continued From page 48 administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure sufficient	A 079		

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A 079	Continued From page 49 staffing was available to meet residents scheduled and unscheduled needs. An observation on at 6:52AM showed 15 residents with only 1 staff on the 3rd. floor. An observation on at 7:08AM showed 10 residents with only 1 staff on the 4th. floor. In an interview on at 12:25PM, the Administrator was informed that there were only one staff member on the 3rd. floor for 15 residents and one staff member on the 4th. floor for 10 residents, the Administrator stated, "I do not know why because they clocked in to work this morning". It was also asked if the assigned staff on the 3rd. and 4th. floors were working on different floors, the Administrator stated, "No". Review of facility's staff schedule showed Staff B and Staff H being assigned to the 3rd. floor and Staff D and Staff K being assigned to the 4th. floor. (Photographic evidence obtained) Class III	A 079		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (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	A 152		

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A 152	Continued From page 50 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 observation and interview, the facility failed to provide a safe living environment, and it failed to maintain all existing architectural, mechanical, electrical and structural systems in good repair. Findings: An observation on at 6:55AM, showed a mattress against the wall in #	A 152		

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A 152	Continued From page 51 An observation on at 7:07AM, showed a mattress in the closet area in # . An observation on at 7:43AM, showed a mattress against the wall in # . In an interview on at 8:15AM, the Administrator was asked why in # was a mattress against the wall, the Administrator stated, "This family has gone through a lot, and the daughter does not want to get rid of it". Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from	A 160		

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A 160	Continued From page 52 which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C.	A 160		

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SUNRISE OF CORAL GABLES	1000 PONCE DE LEON BLVD CORAL GABLES, FL 33134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 53 (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's . . . prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970609	A. BUILDING: _____ B. WING _____	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CORAL GABLES	1000 PONCE DE LEON BLVD CORAL GABLES, FL 33134

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A 160	Continued From page 54 This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to cooperate with agency personnel during a compliant investigation by not providing staff records, medical records, staff training and their policy and procedures for response to elopement for 1 of the 12 sampled Staff (Staff D) and the health assessments for 12 of the 31sampled residents. (Residents #1, # 2, # 3, #4, #5, #4, #5, # 6, # 7, #8, #9, # 10, #11,#12, #13, #30). Findings include: During and interview on at 9:20am A request was made for the health assessment of the non-ambulatory residents (Residents #1, # 2, # 3, #4, #5, #4, #5, # 6, # 7, #8, #9, # 10, #11,#12, #13, #30). At 9:43am The Administrator provided the Agency Personnel with documents titled "Resident's Evaluation Form's". During an interview on at 10:02am the Administrator stated the records are all electronic and they are trying to print the documents out but the printer is slow. A record review of the Staff D personnel file on at 8:50am found no documentation on Elopement Training, Control, /First Aid, Behavior Training and Reporting Major Incidents. During an interview on at 9:25am the Administrator stated all the staff files are electronic, they have a program that the employees go on and complete the trainings and he can go online to print them out. Additional request was made for training, however the	A 160		

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
	AL11970609	A. BUILDING: _____ B. WING _____	12/15/2025

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A 160	Continued From page 55 Administrator failed to provide the requested documents. Class III	A 160		