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
	AL11965291	A. BUILDING: _____ B. WING _____	C 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS TALLAHASSEE	2110 Fleischmann Road TALLAHASSEE, FL 32308

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A 165 SS=G	429.23(1-4 & 6-10) 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 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. Death; 2. Brain or spinal damage; 3. Permanent disfigurement; 4. Fracture or dislocation 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	A 165		

AHCA Form 3020-0001

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

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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 of the facility's investigation into the adverse incident.
(6) Abuse, neglect, or exploitation 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

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A 165	Continued From page 2 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. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to report an adverse incident to the Agency for Healthcare Administration (AHCA) regarding a kitchen fire with smoke entering the main living area requiring staff to evacuate all residents out of the facility resulting in a resident death. (Resident #1) Findings included: An interview was conducted on 01/14/26 at 11:00 AM with the facility Administrator. The Administrator stated the incident dated 01/06/26 was not reported to AHCA and was only reported to the corporate office because there were no employee injuries and no structural damage to the facility. The Administrator confirmed there was 1 resident death but stated it was "already imminent" due to the resident being on hospice services. An interview was conducted on 01/15/26 at 10:37 AM with the facility Health and Wellness Director. The Health and Wellness Director confirmed the incident reported to corporate involved the fire incident that took place on 01/06/26.	A 165		

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A 165	Continued From page 3 In reference to the fire that took place on 01/06/26, the facility provided a corporate report, dated 01/11/26. Review of the report revealed the staff member had left butter melting on the stove for too long and it caught on fire. The staff had to use a fire extinguisher to put out the fire. The report documented that the fire had burned long enough that it caused smoke to accumulate in the kitchen, dining room, living room, and common areas. However, there was no physical damage done to the building. Once they noticed the fire, the staff member responsible removed the skillet from the stove and carried it to the sink. This action caused the staff member to suffer a burn to the right side of his face. The report documented one resident, Resident #1, passed away while waiting outside during the evacuation with her daughter. The report also confirmed that the local Fire Department responded. Class II	A 165		
A 180 SS=D	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, September 2023, incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964. The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml. The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards;	A 180		

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A 180	Continued From page 4 (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with Alzheimer's disease or related disorders, and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to renew the approval of the Comprehensive Emergency Management Plan (CEMP) on an annual basis.	A 180		

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A 180	Continued From page 5 The findings include: A review of the facility's CEMP was conducted, which revealed the CEMP was last submitted to and approved by the county on 10/11/24. An interview was conducted on 01/15/26 at 10:37 AM with the facility's Administrator. The Administrator confirmed the CEMP letter was not approved for this year. Class III	A 180		
A 000	Initial Comments An unannounced complaint survey for complaint #2026000349 was conducted at Sodalis Tallahassee, an assisted living facility in Tallahassee, FL, on 01/14/26 and 01/15/26. Deficiencies were identified at the time of survey. A Class I deficiency was found at Tag A0152. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The Class I noncompliance began on 01/14/2026. The facility's Administrator was notified of the Class I noncompliance on 01/15/26 at 4:30PM. The census at the start of the survey was 76. The following is a description of the deficiencies found at the time of the visit.	A 000		

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A 030 SS=F	59A-36.007(5) FAC; 429.28(1-2) 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 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; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE 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;	A 030		

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2. Alcohol and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident abuse, neglect, and exploitation;
6. Administrative and housekeeping schedules and requirements;
7. Infection control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical restraints.

(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

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A 030	Continued From page 8 facility shall have the right to: (a) Live in a safe and decent living environment, free from abuse 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 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	A 030		

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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 appointments for health care services, the provision of or arrangement of transportation to health care appointments, 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 incapacitated, 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

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A 030	Continued From page 10 of the facility, governing officials, or any other person without restraint, 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. (2) The administrator of a facility shall ensure that a written notice of the rights, obligations, 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 Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability 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 Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida. 429.27 Property and personal affairs of	A 030		

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A 030	Continued From page 11 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 incompetent or incapacitated 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 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 and interview, the facility failed to ensure the residents' right to a safe living environment. The facility also failed to ensure hazardous materials were properly stored outside the facility. This had the potential to expose all 76 residents at the facility to potential harm. The findings include: An interview was conducted on 01/14/26 at 11:00 AM with the facility's Administrator. The Administrator confirmed the facility had experienced two kitchen fires within a one-month period. The Administrator stated the first fire occurred on 12/18/25 in the kitchen area. She stated this fire was caused due to a mixture of grease-soaked towels and chemical-soaked towels being put together in one sanitation	A 030		

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A 030	Continued From page 12 bucket. She stated the bucket was located by a 3-compartment sink when it caught on fire. She stated the second fire occurred on 01/06/26 when the same staff member left a pot of butter on the stove which caught fire when the employee left the kitchen, leaving the pot unattended for an unknown period of time. During a tour of the facility conducted on 01/14/26 at 11:06 AM, an unlocked, open mechanical room door located directly outside the kitchen area was observed. Inside this room, a 2-gallon fuel can which was full of fuel was observed. The fuel can was sitting on top of a workbench located within the mechanical room. An interview was immediately conducted with the facility Maintenance Director. The Maintenance Director confirmed he put the fuel can in the room on 01/09/26 because he was pressure-washing the building and did not want to leave the fuel outside over the weekend. The fuel can was removed at this time by the Maintenance Director and placed outside of the facility in a yellow fuel container box. Class III	A 030		
A 075 SS=D	429.255(3-5) FS Use of Personnel; Emergency Care (AED) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical	A 075		

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A 075	Continued From page 13 director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency Automated External Defibrillator (AED) was maintained for safe use. The findings include: A tour of the facility was conducted on 01/14/26 at approximately 10:00 AM. An observation was made of facility's emergency equipment, including an AED with defibrillator pads. This AED was located on the first floor of facility. Closer	A 075		

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A 075	Continued From page 14 inspection revealed the pads had an expiration date of 05/08/25. There was no documentation to show inspections of the equipment and pads to ensure the AED was in safe, operable condition. An interview was conducted on 01/14/26 at approximately 1:00 PM with the facility Health and Wellness Director. The Health and Wellness Director confirmed that the AED pads expired on 05/08/25. They retrieved an additional AED device that had been located in their office. However, at that time, the AED would not power on. Class III	A 075		
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 disease. 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 tuberculosis 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 tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must	A 078		

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A 078	Continued From page 15 submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis. 2. If any staff member has, or is suspected of having, a communicable disease, 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 constitute a risk of transmitting a communicable disease. (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 contracting 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	A 078		

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A 078	Continued From page 16 conducted for staff, including staff contracted 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 staff record reviews and interviews, the facility failed to ensure all current staff were included on the Background Clearing House Roster for 4 of 10 staff sampled. (Staff A, B, D, and I) The findings include: A review of staff records was conducted, including the information available on the Background Screening Clearing House roster. During this review, it was noted that four staff members were missing from the roster: Staff A (Culinary Director) - hire date 10/26/25, Staff B (Health Wellness Director) - hire date 08/16/25, Staff D (Cook)- hire date of 11/17/25, and Staff I (Administrator) - hire date of 10/17/25. An interview was conducted on 01/15/26 at approximately 6:30 PM with the facility's Administrator. The Administrator confirmed she was responsible for ensuring all staff rosters are complete and up to date. She acknowledged the four staff members that were missing from the clearing house roster and stated she was aware that the staff members needed to be added. Class III	A 078		
A 080 SS=D	429.52(2-3) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility	A 080		

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A 080	Continued From page 17	A 080		

staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.
(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:
(a) State law and rules relating to assisted living facilities.
(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.
(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.
(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.
(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.
(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.
(g) Care of persons with Alzheimer's disease and related disorders.

59A-36.011
(1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.
(a) The assisted living facility core training requirements established by the department

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A 080	Continued From page 18 pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.	A 080		

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A 080	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all current staff were properly trained in evacuation protocol regarding residents located on the second level of the facility in an event of a emergency. The findings include: Review of the facility's fire policy revealed the fire policy did not have a plan on how staff is supposed to evacuate the residents safely from second floor of the facility in the event of a fire without using the facility's elevator. A tour of the facility was conducted on 01/14/26 at approximately 10:00 AM. During this tour, it was noted that the facility did not have emergency equipment to evacuate residents from the second floor to main floor using the stairwells. An interview was conducted on 01/15/25 at approximately 12:38 PM with the facility Health and Wellness Director. The Health and Wellness Director reported it was facility policy that in the event of a fire, all residents needed to evacuate. They stated, "We haven't used the stairwell to get them down to evacuate. We have been using elevators". They further stated residents that were not able to walk downstairs would be assisted by staff and for residents that could not walk downstairs, they "would use sheets as a gurney to get them down" due to the fact that the facility had no emergency equipment available for staff to use. "We don't have anything in place", the Health and Wellness Director admitted. "After the fire, it was discussed on what to do, but it was not	A 080		

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A 080	Continued From page 20 documented". Class III	A 080		
A 152 SS=L	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 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 height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, chest 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.	A 152		

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A 152	Continued From page 21 (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 threadbare. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure all residents were free of hazards and living in a safe environment due to two kitchen fires occurring within one month. This had the potential to expose all residents at the facility to potential harm. The findings include: An interview was conducted on 01/14/26 with the facility's Dietary Manager. The Dietary Manager reported that two fires had occurred, one on 12/18/25 and the other on 01/06/26. The Dietary Manager stated there was no damage to the building and no repairs were needed. They confirmed the fire alarm did go off and the Fire Department did respond to both fires. She stated, "I was able to extinguish the fire with the fire extinguisher", confirming she used a regular, multipurpose fire extinguisher. She stated the Maintenance Director replaced the fire extinguisher after it was used. In reference to the fire that took place on 01/06/26, the facility provided a corporate report dated 01/11/26. The report revealed a staff member had left butter melting on the stove for too long and it caught on fire. The staff member had to use a fire extinguisher to put out the fire. The report documented that the fire had burned long enough that it caused smoke to accumulate in the kitchen, dining room, living room, and	A 152		

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common areas. However, there was no physical damage done to the building. Once they noticed the fire, the staff member responsible removed the skillet from the stove and carried it to the sink. This action caused the staff member to suffer a burn to the right side of his face. The report documented one resident, Resident #1, passed away while waiting outside during the evacuation with her daughter. The report also confirmed that the local Fire Department responded.

An interview was conducted on 01/14/26 at 12:38 PM with the facility's Health and Wellness Director. The Health and Wellness Director reported Resident #1 passed during the second fire. They stated Resident #1 was sitting in her wheelchair in her room with her daughter when the fire alarm sounded. They stated the staff were knocking on doors to evacuate residents. They recalled Resident #1's daughter offered to push her down to the evacuation area while the staff gathered the other residents. The Health and Wellness Director recalled, "We were getting the all-clear to take residents back to room and that's when a staff member notified me. I checked her pulse and did not get one on her carotid or radial. I checked both and didn't feel a pulse." They further recalled they observed for signs of breathing and noted Resident #1's color had changed and she was cold to touch. They asked one of the staff to contact Resident #1's hospice provider regarding her status. A staff member from the hospice provider responded and pronounced Resident #1 later that day.

Review of Resident #1's medical record revealed she was enrolled in hospice services for a terminal diagnosis. A note from the hospice nurse documented Resident #1 was "imminent" one week prior to the fire that happened on 01/06/26.

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A 152	Continued From page 23 During a tour of the facility conducted on 01/14/26 at 11:06 AM, an unlocked, open mechanical room door located directly outside the kitchen area was observed. Inside this room, a 2-gallon fuel can full of fuel was observed. The fuel can was sitting on top of a workbench located within the mechanical room. An additional tour and observation revealed the fire alarm in the kitchen above the worktable area was noted to be in a diagonal position that was not secured to the wall. The exit door egress bar was also noted to be broken and hanging down by stairwell A. An interview was immediately conducted with the facility Maintenance Director. He stated, "we started pressure washing the outside of the facility on Friday, 01/09/26. I set it [referring to the 2-gallon fuel can] inside the building to store it until Monday, 01/12/26. We don't normally store fuel in the building. We have a small fuel storage cabinet located outside by the generator but I can't open it and it's old, so I don't use it." The fuel can was removed after the investigation to an outside storage container. Class I	A 152		