

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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
ZZ821	59A-35.110() FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPo rtal. 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?N o=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPo rtal.	ZZ821		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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	
ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , which is hereby incorporated by reference and available	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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
ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, _____, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, _____, which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123 , and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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	
ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to \$50 per day late not to exceed \$500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on the facility reviews and interviews, the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 days of the incident for 1 of 1 sampled residents. (#1) Findings:	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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	
ZZ821	Continued From page 4 Review of resident #1's record revealed a facility admission on A 1823 health assessment indicated a medical history of and was identified as an elopement risk. A facility note on read, resident stated to call 911 because something got stuck in his after brushing his The facility called 911 to come. Upon arrival he stated that he tried to hurt and kill himself. He was transported to the hospital. A facility note on read, resident was last seen around 10:30 AM at the living area. We were unable to locate around 11 AM for lunch. The facility called 911 and around 11:25 AM the resident was found across the street sitting and talking to the officer. The police and the resident walked to the facility with the staff. A facility note on read, resident went to patio. The staff followed and the resident attempted to climb the wooden gate. The staff tried to stop him, and he stated he would kill himself. The facility called 911 and they arrived with the police around 8 AM. The resident was sent to the hospital. Caregiver A was asked to provide all incident reports submitted to the agency from to the current year 2026. On at 12:00 PM, Caregiver A provided 1 incident report stating that's all she was able to find. On at 12:40 PM, the Administrator stated the one report provided was the only incident that	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

1535 CARE

APOPKA, FL 32703

(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
ZZ821	Continued From page 5 the facility has submitted in over 2 years and has not had any additional adverse. Further stating, she was unaware of the regulations and what incidents should be reported. On at 4:05 PM, Caregiver D stated she does not submit the reports, and the Administrator is responsible for submitting to the agency any incidents. On at 4:57 PM, the Administrator confirmed the findings. Unclassified	ZZ821		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of . A record of the completion of the	ZZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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	
ZZ875	Continued From page 6 training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide,	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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
ZZ875	Continued From page 7 specialized care for persons with _____'s or related forms of _____, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of _____-specific training. Such training must include, but is not limited to, understanding _____ and related forms of _____ _____, the stages of _____'s _____, communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning _____. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or _____-on experience to help develop and refine the employee's skills for caring for a person with _____'s _____ or a related form of _____. The continuing education must cover at least one of the topics included in the _____-specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an	ZZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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	
ZZ875	Continued From page 8 electronic learning _____, chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, _____, or referred to provide services before _____ must complete the training required in this section before _____. Proof of completion of equivalent training completed before _____ shall substitute for the training required in subsection (4). Each person employed, _____, or referred to provide services on or after _____, may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6).	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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
ZZ875	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff completed a 1-hour training program on _____ and Related (ADRD) within 30 days after beginning employment. (A, C, D) Findings: Review of Caregiver C's personnel record revealed a hire date on _____. Review of Caregiver A's hire date on _____, and Caregiver D's hire date on _____. There was no documentation the caregivers completed the 1hr ADRD and the additional 3hrs within 7 months to meet the new training requirements. On _____ at 3:48 PM, Caregiver A stated they do not have the training yet for the Department of Elder Affairs. On _____ at 4:57 PM, the Administrator confirmed the finding, further stating she was not aware of the new training requirements. (photographic evidence obtained) Class III A 000 Initial Comments A complaint investigation #2025017928 and generator monitoring was conducted at Greenbriar Retirement Home on ____/2026.	ZZ875		
		A 000		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

1535 CARE

APOPKA, FL 32703

(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	Continued From page 10 The facility had deficiencies at the time of the survey.	A 000		
A 008 SS=D	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 008	Continued From page 11 Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

**1535 CARE
APOPKA, FL 32703**

(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 008	Continued From page 12 whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of . . . require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- . . . medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or . . . services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of . . . or any other communicable . . . , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and,	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

1535 CARE

APOPKA, FL 32703

(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 008	Continued From page 13 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 008	Continued From page 14 Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, _____, or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida _____ Form, for residents who do not wish _____ to be administered in the case of _____ or _____. (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain an AHCA Form, 1823 Health Assessment as required for 1 of 2 sampled residents (#1). Findings: Review of resident #1's record revealed a facility admission on _____. Further review revealed no evidence of an admission 1823 was obtained.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 008	Continued From page 15 On at 4:05 PM, the Administrator stated the 1823 health assessment was his original and the examiner dated incorrectly. Adding, the resident came from 'Veteran Affairs' (VA) in Ft. Lauderdale in 2023. On at 4:05 PM, Caregiver D stated I'm sure we received it as the documents from the VA are dated . On at 4:57 PM, the Administrator confirmed the findings and provided no additional documentation. The facility failed to ensure resident #1 obtained a -to- medical examination completed by a health care practitioner completed within 60 days before or within 30 days after the individual's admission to the facility. (photographic evidence obtained) Class III	A 008			
A 010 SS=D	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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 010	Continued From page 16 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 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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

**1535 CARE
APOPKA, FL 32703**

(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 010	Continued From page 17 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. (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	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

1535 CARE

APOPKA, FL 32703

(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 010	Continued From page 18 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 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,	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 010	Continued From page 19 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. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews the administrator failed to determine the continued appropriateness of placement for 1 of 2 sampled residents (#1); and failed to obtain a new AHCA 1823 Health Assessment for continued residency after a significant change in 1 of 1 sampled resident (#1). Findings: On _____ at 11:30 AM, during the tour Caregiver A identified resident #1 who was observed sitting in the common area with several other residents participating in an activity. Review of resident #1's _____ 1823 health assessment indicated a medical history of _____ and was identified as an elopement risk. Further review indicated "NO" for the	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 010	Continued From page 20 question pose a danger to self or others. Further review of resident #1's record revealed a health assessment dated . The resident was not identified as an elopement risk. On resident #1 eloped from the facility and was found by law enforcement across the street. A facility note on , resident stated to call 911 because something got stuck in his after brushing his . The facility called 911 who arrived at the facility and the resident said to them that he tried to hurt and kill himself. The resident was transported to the hospital. A facility note on , resident went to patio. Resident attempted to climb the wooden gate. Staff tried to stop him. "Resident stated he would kill himself." On at 3:52 PM, Caregiver D stated each time resident #1 said he would kill himself he was sent out to the hospital. The hospital would send him right with no changes. On at 4:45 PM, the Administrator stated we told his doctor and he came out to assess him. She stated the doctor said when he asked him how he would kill himself. He could not explain therefore he was not a threat. Also, we spoke with resident #1's family member about getting a psych evaluation and she didn't believe it was needed because he would say it all the time before moving to the facility that he wanted to kill himself. On at 2:31 PM, The doctor stated during a phone call that he was not aware that resident #1 wanted to kill himself nor did the facility tell him. Adding, I don't think resident #1 would kill	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

1535 CARE

APOPKA, FL 32703

(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 010	Continued From page 21 himself or commit , but then again there are people who don't show any signs and they do it. So, I guess it's hard to say. He further stated I believe resident #1 has issues with a family member and says that to get attention. (photographic evidence obtained) Class III	A 010		
A 025 SS=G	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. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 025	Continued From page 22 (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 record reviews and interviews, the facility failed to provide adequate supervision to 1 of 1 sampled resident who eloped from the facility by maintaining a general awareness of the resident whereabouts and emotional general well-being (#1). Findings: Review of an incident report dated	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 025	Continued From page 23 indicated an event reported to law enforcement and resident elopement. Further stating, apparently, resident jumped over the 6ft fence using a big empty garbage pail to get over the other side of the fence onto the street. Review of the police report dated _____ at 12:48 PM stated the police was called due to resident #1 missing and was located near McNeil Rd and Eden Park Road in Apopka, FL. On _____ at 11:52 AM, resident #1 stated it was a bad mistake, and he was stupid for doing it, when asked if he recalls leaving the facility going over the fence. The resident stated he thinks he tried to leave 2 -3 times but now realizes this is where he needs to be. Review of resident #1's record revealed an admission date on _____ A _____ 1823 health assessment indicated a medical history of _____ and was identified as an elopement risk. A facility note on _____, seems to be forgetful, likes to pack and unpack his backpack. A facility note on _____, forgetful but easy to redirect. A facility note on _____, doesn't sleep good at nighttime per night staff. Keeps on packing his clothes. A facility note on _____, _____ 50 mg (milligram) at bedtime, telephone order by facility doctor. A facility note on _____, forgetful, pleasantly _____, but easy to redirect.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

1535 CARE

APOPKA, FL 32703

(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 025	Continued From page 24 A facility note on _____ seems to be doing fine, forgetful. A facility note on _____, seen and examined by Facility Doctor for monthly monitor, no changes made. A facility note on _____, doing fine, forgetful at times but very pleasant. A facility note on _____, seen and examined by Facility Doctor for monthly monitor, no changes made. A facility note on _____, resident exercise on patio and would like to sit under the sun for a while daily. A facility note on _____, forgetful at times. Occasionally he would ask for his luggage, stating he would go to Ft. Lauderdale, some would pick him up. A facility note on _____, seen and examined by Facility Doctor, no changes been made. A facility note on _____, noted pictures in the trash can. A facility note on _____, at around 1:10 PM, resident went to staff stated to call 911 because something was stuck in his _____ after brushing his _____. The facility called 911 and they arrived at the facility. Resident stated he tried to hurt and kill himself. A facility note on _____, resident came from the hospital with the 1823. Same list of medications with new order of _____, 25 mg 1	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 025	Continued From page 25 tablet at bedtime. A facility note on _____, resident last seen around 10:30 AM at the living room. Unable to locate around 11:00 AM for lunch. Check all rooms and closets, backyards. Called 911 around 11:25 AM. Resident was found across the street sitting and talking to an officer. The resident and police walked _____ to the facility with staff. A facility note on _____, frequently check every 30 minutes when sitting in the living room. Constantly monitor when inside his room for hours. A facility note on _____, start _____ 5 mg 1 tablet by _____ two times a day increased to 10 mg twice a day after a month. _____, 5 mg 1 tablet by _____ every morning (increase 10 mg in a month) family notified. A facility note on _____, seen and examined by Facility Doctor, no changes been made. A facility note on _____, resident went to patio. The staff followed and the resident attempted to climb the wooden gate. Staff tried to stop him, and he stated he wanted to kill himself. The facility called 911 and arrived with police officer around 8 AM. Around 2:10 PM, resident returned from the hospital with no changes made. Family notified. A facility note on _____, start _____, 10 mg 1 tablet by _____ daily. A facility note on _____, seen and examined by Facility Doctor, no changes been made. A facility note on _____, resident did not sleep	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 025	Continued From page 26 well, and night staff will monitor. A facility note on read, resident attempted to go out of the building at around 9:30 AM by climbing the gate at . Staff were able to bring him down and take him inside the facility. A facility note on read, start 50 mg 1 tablet by twice a day, 10 mg 1 tablet by at bedtime, discharge (d/c) 25 mg evening, 50 mg by A facility note on read, resident was not around in the living at 12:00 PM and was last seen around 11:50 AM. Two caregivers started searching around the premises of the facility and 2 caregivers were driving around the road. A caregiver found his jacket along the road near Ballistyne gated community. Resident was transported to hospital. A facility note on read, resident came from the hospital around 9:30 AM. A facility note on read, constantly checking every minutes. Gate at the has been put higher than previous A facility note on read, air tag attached to resident pants and shoes. On at 3:03 PM, the family member of resident #1 stated she was made aware each time resident #1 eloped from the facility. Adding, he's only left two times and the other 2 times the facility was able to stop him. Further stating, the facility is a secure memory care and unsure how this keeps happening. The family member stated she's aware that resident #1 wants to go to	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 025	Continued From page 27 FL. Lauderdale. The family member was made aware the facility was not a licensed memory care unit. On at 3:52 PM, Caregiver D stated after the first time resident #1 eloped on we did the fence, but it was not high enough and he was able to get out again. The second time, on he used the garbage can to climb the fence, so we put the fence higher by adding more boards to prevent him from climbing over. We put air tags in his shoes, do more monitoring by keeping him in the common area with the other residents. He's only allowed outside when he asks and a caregiver will watch him. On at 4:05 PM, the Administrator stated the facility put air tag on the resident to monitor him and added a wood boarding along the chain link fence to prevent resident #1 from climbing over. Further stating the family member of resident #1 did not want him to be seen by a On at 4:57 PM, the Administrator confirmed the findings. On at 2:31 PM, the Facility Doctor stated he was unaware that resident #1 had eloped on as he only visits the facility once a month and the facility did not make him aware. Adding, he will monitor resident #1 and advise the facility he may require a more secure unit if he continues to leave. Review of the facility's note indicated the Facility Doctor visited on and did not return until (photographic evidence obtained) Class II	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703			
(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 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 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.	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703		
(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 032	Continued From page 29 (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 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 observation, record reviews, and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1). Findings: During an interview with resident #1 he was asked if he had an ID bracelet that has his name, facility's name, address, and phone number. On _____ at 11:52 AM, resident #1 stated after	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREENBRIAR RETIREMENT HOME

**1535 CARE
APOPKA, FL 32703**

(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 032	Continued From page 30 checking both _____ that he did not have an ID on and does not recall wearing one at all. Review of resident #1's record revealed a facility admission on _____. A _____ 1823 health assessment identified him as an elopement risk. On _____ at 12:40 PM, during a phone call, the Administrator stated the facility put an ID bracelet on resident #1's _____ and they check for it daily. Further stating, he should have one on now. The Administrator was made aware that the resident did not have an ID bracelet on his _____ or ankles. On _____ at 1:05 PM, escorted by Caregiver A resident #1 was asked to remove his jackets to determine if he had an ID bracelet on his _____. After removal of 2 jackets, it was determined that the resident did not have an ID bracelet on his left or right _____ as previously stated by the Administrator. On _____ at 2:13 PM, Caregiver A stated we noticed after you told us and we put it on him. She explained we sometimes check every day and only put an ID bracelet on the last time he left in _____, not the first time in _____. Observation revealed resident #1's ID bracelet was placed on his _____. On _____ at 4:05 PM, Caregiver D stated we did not put an ID bracelet on resident #1 the first time he tried to leave. We put the tracker in his shoes in _____. On _____ at 4:05 PM, the Administrator stated they check daily for resident #1's ID bracelet. Adding, he had it on yesterday. The caregiver	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964457	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER GREENBRIAR RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1535 CARE APOPKA, FL 32703			
(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 032	Continued From page 31 removed it when giving him is shower and probably forgot to put it on. She further stated they did not document it and was unable to provide any evidence to support the bracelet being checked daily. Class III	A 032			