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
	AL11968448	A. BUILDING: _____ B. WING _____	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

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

AHCA Form 3020-0001

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

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A 081	Continued From page 1 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents	A 081		

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

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A 081	Continued From page 3 understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 2 of 7 sampled staff (A, C) received training on the facility's policies on resident , neglect, and , and on resident elopement. Findings: A review of caregiver A's personnel record revealed a hire date of . A review of caregiver C's personnel record revealed a hire date of . Neither record contained documentation to indicate the caregivers received training on the facility's policies on resident , neglect, and , and on resident elopement. During an interview on at 10:25 AM, the Business Office Manager said the caregivers did not receive the training. Class III	A 081		
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening	ZZ814		

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ZZ814	Continued From page 4 Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made. (d) An employer or a qualified entity participating in the clearinghouse must register with and	ZZ814		

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ZZ814	Continued From page 5 initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interviews, record review, and review of the facility's care provider background screening clearinghouse, the facility failed to report the employment status of 1 of 7 sampled staff (B) within 5 business days. Findings: A review of nurse B's personnel record revealed a hire date of . A review of the facility's care provider background screening clearinghouse on at 4:25 PM revealed nurse B was not on the roster. During an interview on at 9:35 AM, the Business Office Manager said she forgot to add nurse B to the clearinghouse roster. Unclassified	ZZ814		

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ZZ821	Continued From page 6	ZZ821		
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/SingleSignOnPortal: 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?No=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:	ZZ821		

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ZZ821	Continued From page 7 https://apps.ahca.myflorida.com/SingleSignOnPortal. 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,	ZZ821		

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ZZ821	Continued From page 8 AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available 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.	ZZ821		

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ZZ821	Continued From page 9 7. For the purposes of this rule, the following applies for submitting adverse incident reports: 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 record review and interview, the facility failed to submit electronically a report within 1 business day and within 15 calendar days after the resident experienced a after being pushed by another resident and was transferred to the	ZZ821		

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ZZ821	Continued From page 10 hospital for 1 of 5 sampled residents (#11). Findings: Review of resident #9's record revealed a facility admission date of . The residents' medical history included 's . Review of resident #11's record revealed a facility admission date of . The resident's medical history included 's . Review of a facility note, dated at 5:18 PM, revealed a caregiver reported that she was walking in the hallway with resident #10 when resident #9 passed them and told resident #10 to shut up. Resident #9 then pushed the resident to the floor. Resident #9 was walking around the community saying that he needed to get rid of more people. Resident #9 became aggressive towards staff when they tried to redirect him. Review of a facility note, dated at 5:20 PM, revealed a caregiver reported that she and resident #11 were walking in the hallway. The caregiver stated resident #11 was calling for his wife. Resident #9 was passing by resident #11 and the caregiver. Resident #9 told resident #11 to shut up and then resident #9 pushed resident #11 on the floor. Resident #11 hit his . Resident #11 was lying in a supine position with his closed. At 1:45 PM, 911 was called and resident #11 was transported to a hospital. Review of a hospital record, dated , revealed that resident #11 complained of , and his right was red and watery. During an interview on at 8:45 AM, the Administrator said that on , resident #11	ZZ821		

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ZZ821	Continued From page 11 was walking in the hallway looking for his wife. The Administrator said that for some unknown reason, Resident #9 pushed resident #11 down to the carpeted floor. The Administrator said that both residents were sent to a hospital for evaluation. During an interview on at 8:55 AM, the Maintenance Director said he arrived at the scene on to find resident #11 lying in the hallway on the floor. The Maintenance Director added, resident #11 seemed as though he was out of it. The Maintenance Director said that resident #9 was looking over his and the other staff , making verbal threats. During an interview on at 1:35 PM, caregiver L said that on 11/28/25 resident #11 was walking in the hallway talking. Resident #9 seemed upset and pushed resident #11 on the ground. The caregiver said she called the nurse and resident #11 was sent to the hospital. The caregiver said that resident #9 was not upset until he heard resident #11 in the hallway. During an interview on at 12:31 PM, the Administrator said she did not submit the required reports because resident #11 did not sustain an injury. 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	ZZ875		

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ZZ875	Continued From page 12 must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each 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 '	ZZ875		

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ZZ875	Continued From page 13	ZZ875		

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

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SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

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ZZ875	Continued From page 14 electronic learning ـــ. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning ـــ 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.	ZZ875		

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ZZ875	Continued From page 15 (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 7 sampled staff (J) completed a 1-hour training program on and Related forms of (ADRD) provided by the Department of Elderly Affairs within 30 days after beginning employment and failed to ensure 1 of 7 sampled caregivers (G) participated in at least 4 hours of ADRD continuing education each calendar year. Findings: A review of caregiver G's personnel record revealed a hire date of . The record contained certificates of training, dated , on ADRD levels 1 and 2. The record did not contain documentation to indicate the caregiver participated in at least 4 hours of ADRD continuing education annually thereafter.	ZZ875		

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ZZ875	Continued From page 16 During an interview on at 1:52 PM, the Administrator said caregiver G did not participate in ADRD continuing education during the year 2025. Review of Caregiver J's personnel record revealed a hire date of . The record did not contain documentation to indicate she completed a 1-hour training course on ADRD provided by the department of elderly affairs within 30 days after beginning employment. On at 10:23 AM, the Business Office Manager, said Caregiver J did not submit her information about elder affairs to receive a certificate when she watched the training. Class III	ZZ875		
A 000	Initial Comments A complaint investigation (#2026000370) and a generator monitoring were conducted at Serenades by West Orange on and . Deficiencies were identified at the time of survey.	A 000		
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	A 025		

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A 025	Continued From page 17 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. (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	A 025		

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A 025	Continued From page 18 resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision when 1 of 5 sampled residents eloped from the facility (#9,) failed to provide adequate supervision to prevent resident to resident for 3 of 5 sampled residents (#9, #10, #11,) and failed to document in the resident's record when 1 of 5 sampled residents sustained an , injury (#11.) Findings: 1. A review of resident #11's record revealed a medical history of 's . During an interview on at 9:39 AM, caregiver E said that on at about 5 AM she and caregiver C were helping resident #11 in his bathroom. Caregiver E said she left the bathroom briefly and when she returned, she saw one of the residents' , was bloodshot. Caregiver E said that caregiver C said the resident hit himself in his , with his . Caregiver E said she notified nurse B of the injury. Continued review of resident #11's record revealed there was no documentation of the injury.	A 025		

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A 025	Continued From page 19 Observations made on at 10:18 AM revealed resident #11 was sitting on a sofa in the dayroom. He was alert and made , contact. He mumbled softly. His words were nonsensical. He became tearful. Light redness was seen on his left outer . During an interview on at 11 AM, nurse B said that on caregiver E did report the , injury. Nurse B said she looked at the , and saw a broken in the resident's left , . The nurse said she told Advanced Practice Nurse Practitioner (APRN) I when she visited that day. Nurse B said she did not document the injury in the resident's record because there were other things going on. During an interview on at 11:28 AM, caregiver C said that on she and caregiver E were providing care to the resident in his bathroom. Caregiver C said that when caregiver E's was turned, the resident rubbed his , causing the broken . During an interview on at 12:15 PM, APRN I said she looked at the resident's , during her visit on . The APRN said there was a broken . The APRN said she did not see , and . 2. A law enforcement call history record dated indicated a call was received at 3:47 PM. The record indicated the location of occurrence was a rehabilitation facility, located approximately one-half mile from the facility. The record indicated that resident #9 walked into the rehabilitation facility and said he was lost. The record indicated that the resident's family was contacted, who in turn notified the facility. The record indicated the resident returned to the	A 025		

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A 025	Continued From page 20 facility at 4:21 PM. Review of resident #9's record revealed a facility admission date of . The residents' medical history included 's . Review of resident #9's health assessment Forms (1823,) dated , , and revealed the resident was an elopement risk, exhibited sundowning behavior, and a history of both and elopement. Review of a facility note, dated at 5:40 PM, revealed that around 2 PM the resident was agitated because he wanted to leave the building. The note indicated a nurse was able to calm the resident down and engage him in completing the puzzle he started earlier. The note indicated that at around 4:15 PM, it was learned the resident was not in the facility and was being escorted by law enforcement. The note indicated the resident was unable to say how he got out from the facility. The note indicated that resident #9 was and disoriented. During an interview on at 3:02 PM, the resident's family member said the reason for choosing this facility was due to the security the facility had to prevent residents from eloping. During an interview on at 3:14 PM, the Receptionist said that on at about 4 PM, the resident's family member called the facility to inform them the resident was at a nearby rehabilitation facility. The Receptionist went on to say that law enforcement returned the resident to the facility. The Receptionist also said the resident left the facility through a door being used at the time by painters who had a key fob for the door.	A 025		

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A 025	Continued From page 21 During an interview on at 3:22 PM, Caregiver J said that on at about 4 PM, she observed the resident sitting in the dining room playing with a puzzle. The caregiver said that when it was time for the resident to receive his medications, she did not see him in the dining room. The caregiver said she then went to check his bedroom, other resident rooms, the living room, and hallways, but the resident was not found. The caregiver said that when she went to inform a nurse, she saw the resident was with the nurse. The caregiver said the nurse informed her that the resident eloped from the building and was brought by police. The caregiver said she did not know which door the resident left out of or how he got out of the building. During an interview on at 8:35 AM, the Administrator said the resident was not an elopement risk when he eloped from the facility on . The Administrator said the facility had painters at the time who thought the resident was an employee and let the resident out. During an interview on at 10:01 AM, the Administrator reviewed the residents' 1823s and confirmed the resident was identified as an elopement risk. During an interview on at 11:12 AM, nurse N said that on she last saw the resident after lunch doing a puzzle. The nurse said the resident's family member called her and said the resident was at a nearby rehabilitation facility and would be returned by law enforcement. The nurse went on to say the resident sometimes exhibited exit seeking behavior at about 2:30 PM. During an interview on at 12:50 PM, the	A 025		

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A 025	Continued From page 22 Maintenance Director said he was not at the facility on because it was a weekend. However, he gave the painters a key fob because they needed to go through the community. Review of an elopement policy with a revision date of , indicated an elopement refers to an unassisted, unsupervised, unscheduled, absence or departure of a resident from the community. 3. Review of resident #9's record revealed a facility admission date of . The residents' medical history included 's . Review of resident #10's record revealed a facility admission date of . The residents' medical history included . Review of resident #11's record revealed a facility admission date of . The resident's medical history included 's . Review of a facility note, dated at 4:32 PM, indicated that at about 4:15 PM a nurse was called to the Brio community unit by staff. The nurse was informed that resident #9 became very aggressive and towards resident #10, who was sitting in the recliner watching TV. The note indicated that resident #9 pulled the resident from the recliner to the floor, and when staff attempted to help resident #10, resident #9 returned to the recliner and tried to hit staff. The note indicated that resident #9 was and disoriented. Review of a facility note, dated , revealed a nurse was called to see resident #10 who was pulled from the recliner to the floor by another resident. Resident #10 was assisted to the	A 025		

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A 025	Continued From page 23 recliner by staff. During an interview on at 8:44 AM, the Administrator said that on resident #10 was sitting in a recliner. Resident #9 wanted to sit in the recliner, so he grabbed resident #10's arm to try to get him out of the recliner. Resident #10 slipped out of the recliner to his . The administrator said resident #9 was agitated that day. The Administrator said that resident #10 was not injured. During an interview on at 11:19 AM, nurse N said the caregiver informed her on that resident #10 was sitting in the living room making noise. Resident #9 became agitated and pulled resident #10 from the recliner to the floor. Review of a facility note, dated at 5:18 PM, revealed a caregiver reported that she was walking in the hallway with resident #10 when resident #9 passed them and told resident #10 to shut up. Resident #9 then pushed the resident to the floor. Resident #9 was walking around the community saying that he needed to get rid of more people. Resident #9 became aggressive towards staff when they tried to redirect him. Review of a facility note, dated at 5:20 PM, revealed a caregiver reported that she and resident #11 were walking in the hallway. The caregiver stated resident #11 was calling for his wife. Resident #9 was passing by resident #11 and the caregiver. Resident #9 told resident #11 to shut up and then resident #9 pushed resident #11 on the floor. Resident #11 hit his . Resident #11 was lying in a supine position with his , closed. At 1:45 PM, 911 was called and resident #11 was transported to a hospital.	A 025		

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A 025	Continued From page 24 Review of a hospital record, dated , revealed that resident #11 complained of , , and his right , was red and watery. During an interview on at 8:45 AM, the Administrator said that on , resident #11 was walking in the hallway looking for his wife. The Administrator said that for some unknown reason, Resident #9 pushed resident #11 down to the carpeted floor. The Administrator said that both residents were sent to a hospital for evaluation. During an interview on at 8:55 AM, the Maintenance Director said he arrived at the scene on to find resident #11 lying in the hallway on the floor. The Maintenance Director added, resident #11 seemed as though he was out of it. The Maintenance Director said that resident #9 was looking over his and the other staff , making verbal threats. During an interview on at 1:35 PM, caregiver L said that on 11/28/25 resident #11 was walking in the hallway talking. Resident #9 seemed upset and pushed resident #11 on the ground. The caregiver said she called the nurse and resident #11 was sent to the hospital. The caregiver said that resident #9 was not upset until he heard resident #11 in the hallway. The facility's resident policy revised , indicated in a long-term care facility can occur in 3 ways. Family member to resident, staff to resident, and resident to resident. The policy defined , , as willful infliction of injury or harm to the resident's body.	A 025		

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A 025	Continued From page 25 (photographic evidence obtained) Class II	A 025		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 26	A 030		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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A 030	Continued From page 27 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and 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	A 030		

Agency for Health Care Administration

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	AL11968448	A. BUILDING: _____ B. WING _____	01/13/2026

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A 030	Continued From page 28 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 29 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure 1 of 5 sampled residents (#4) lived in a safe living environment when it failed to immediately report an allegation of and immediately remove the employee who allegedly abused the resident.

Findings:

A review of resident #4's record revealed a

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A 030	Continued From page 31 medical history of with , . A court order, dated , determined the resident was totally , . A review of a facility note, dated , indicated the resident was seen by a health care provider for alleged . The note indicated the provider noted a on the resident's . The note indicated the provider stated the was consistent with reported allegation. The note indicated that resident #4 did not complain of , . The note indicated law enforcement responded to the facility to investigate. Observations made on at 9:30 AM revealed resident #4 was sitting in a chair in the dining room. She was alert and verbally responsive. She was pleasantly . She had no visible injuries. During an interview on at 11:56 AM, caregiver A said that on at approximately 2 AM resident #4 was resistive to care. Caregiver A said she called for assistance over the radio. Caregiver A said that caregiver C responded to the resident's room. Caregiver A said that caregiver C stood the resident up from the bed. Caregiver A said the resident said to get out of her room. Caregiver A said that caregiver C placed the resident in bed to change her. Caregiver A said she changed the resident's brief then saw the bed linen was soiled. Caregiver A said that caregiver C told the resident to get up then the resident refused. Caregiver A said that caregiver C grabbed the resident's then the resident slapped caregiver C on her arm. Caregiver A said that caregiver C then slapped the resident's arm then pinched the resident's . Caregiver A said that	A 030		

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A 030	Continued From page 32	A 030		

caregiver C then told the resident that if she did not get out of bed, caregiver C would sit on the bed. Caregiver A said she left the room to care for other residents while caregiver C remained alone in the resident's room. Caregiver A said that 10 to 15 minutes later, she returned to the resident's room and saw caregiver C was still sitting on the bed. Caregiver A said she left the room again. Caregiver A said she returned to the room about 15 minutes later and saw the resident sitting on the side of the bed wearing a shirt and pants on both lower . Caregiver A said that she and caregiver C stood the resident up then pulled her pants up. Caregiver A said the resident was placed in a wheelchair then placed in the common area. Caregiver A said it was then she saw the resident's was red. Caregiver A said she did not look for injuries to the resident's arm. Caregiver A said she reported the incident to nurse B when she arrived at work at 6 AM. Caregiver A said the resident usually needed two caregivers to provide care because the resident first verbally refused and then became physically combative. Caregiver A said she left caregiver C alone with the resident because caregiver A had other residents to change and was uncomfortable with what happened. Caregiver A said she had the Wellness Director's phone number but did not call her immediately because it was 2 AM. Caregiver A said she previously heard caregiver C be rude to residents, specifically talking loudly. Caregiver A said she did not report this because she was newly employed. Caregiver A said she could not remember if she was trained on the policy.

During an interview on at 12:28 PM, caregiver C said that on between 2 AM and 3 AM, caregiver A called for help with resident #4. Caregiver C said that when she

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A 030	Continued From page 33	A 030		

entered the resident's room, she saw the resident sitting on the side of her bed. Caregiver C said the resident and bed linen were soiled with . Caregiver C said the resident said, "I'm not moving." Caregiver C said she told the resident "We need to get you changed; get you in clean clothes." Caregiver C said she told the resident to lay down in bed. Caregiver C said it was then the resident slapped caregiver C's arm. Caregiver C said she told the resident "Don't do that" then swatted at the resident's arm but did not remember connecting. Caregiver C said she did not remember if she pinched the resident's . Caregiver C said she then held the resident's . Caregiver C said she and caregiver A changed the brief and linen and put a clean nightgown on her. Caregiver C said she pleaded with the resident to get in her wheelchair, but she wouldn't. Caregiver C said she stayed in the room for about 45 to 50 minutes while caregiver A left to care for other residents. Caregiver C said that while alone with the resident, the resident slapped and cursed her. Caregiver C said that every now and then caregiver A checked into the room. Caregiver C said she tried to convince the resident to get up. Caregiver C said she was eventually able to put clothes on the resident. Caregiver C said the resident was normally noncompliant and combative during care. Caregiver C said she could not remember if she received training on the policy.

During an interview on at 2:11 PM, nurse B said that she arrived at work on at 6 AM. Nurse B said that while conducting rounds shortly thereafter, caregiver A reported that caregiver C slapped the resident and pinched her . Nurse B said she looked at the resident's and did not see redness. Nurse B said she

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A 030	Continued From page 34	A 030		

did not observe any other part of the resident's body for injuries because caregiver A did not say which part of the resident's body was slapped. Nurse B said she did not question caregiver C. Nurse B said she reported the incident to the Wellness Director when she arrived at approximately 9 AM. Nurse B said she did not call the Wellness Director upon first learning of the incident because she knew the Wellness Director and Administrator were coming in. Nurse B said she did not send caregiver C home immediately upon learning of the incident because she chose to tell the supervisor who would then speak with caregiver C. Nurse B said the resident policy required that suspected be reported immediately. Nurse B said she did not immediately notify the supervisor because immediately did not mean to call the supervisor right away.

During an interview on at 3:30 PM, the Wellness Director said that nurse B informed her of the incident on at about 12:30 PM. The Wellness Director said she then told the Administrator. The Wellness Director said she notified the health care provider who conducted a telehealth visit. The Wellness Director said she performed a full body examination on the resident and found only that her was red. The Wellness Director said the policy required that suspected be reported immediately and to immediately send the alleged abuser home.

During an interview on at 3:37 PM, the Administrator said the Wellness Director informed her of the incident on at about 3:45 PM. The Administrator said that caregiver A and nurse B should have notified her or the Wellness Director immediately. The Administrator said that

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A 030	Continued From page 35 she did not know that caregiver A left caregiver C alone with the resident after the incident. During an interview on at 11:41 AM, the Administrator said that as part of her investigation, she did not interview other residents or family to determine if others were affected because it wasn't in her thought process. The Administrator said she did not interview other staff to determine other incidents witnessed because she was focused on the staff involved in this incident. The policy, dated , required witnessed and alleged to be reported immediately to immediate supervisor and nursing supervisor. The policy also required an employee suspected of to be immediately suspended from the community pending completion of an investigation. A review of the staffing schedule revealed caregiver C worked on until 7 AM, approximately five hours following the alleged . A review of caregiver A's and C's personnel record revealed neither received training on the policy. Class II	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or	A 032		

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A 032	Continued From page 36 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. (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:	A 032		

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A 032	Continued From page 37 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 interview and record review, the facility failed to ensure 1 of 7 sampled staff (K) participated in a minimum of two resident elopement drills each year. Findings: Review of Caregiver K's personnel record revealed a hire date of . Further review of the record revealed Caregiver K completed an elopement training on . Review of the facility's 2025 resident elopement drills revealed the caregiver was not listed as a participant. On at 1:55 PM, the findings were discussed with the Maintenance Director, who said he was not certain if Caregiver K participated in elopement drills in 2025.	A 032		

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A 032	Continued From page 38 (photographic evidence obtained) Class III	A 032		