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
	AL11910541	A. BUILDING: _____ B. WING _____	R 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER'S LANDING	615 FLORIDA AVENUE LYNN HAVEN, FL 32444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced revisit survey was conducted on 1/26/26 - 1/27/26 at Summer's Landing, an assisted living facility in Lynn Haven, Florida. This was a follow-up to a complaint survey completed on 11/10/25. A new complaint survey and another complaint revisit were completed concurrent to this review. Previously cited deficiencies were found not to be corrected during this visit.	{A 000}		
{A 025} SS=D	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 dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. 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 appointments 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}		

AHCA Form 3020-0001

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

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{A 025}	Continued From page 1 (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 review and staff interviews, the facility failed to ensure resident records were updated and resident families and physicians were notified of significant changes in medical status for 2 of 4 residents reviewed for hospitalization. (Resident #5 and #7) The findings include: A review of Resident #5's medical record	{A 025}		

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{A 025}	Continued From page 2 revealed that she was sent to the hospital emergency room on 1/22/26. The record contained no information of contacting her family or physician. A review of Resident #7's medical record revealed he was also sent to the emergency room on 1/22/26. The record contained no information of the reason he was sent to the emergency room and did not contain evidence of contacting his family or physician. An interview was conducted with the Director of Resident Services (DORS) on 1/27/26 at 11:30 AM. She stated the facility had no other documentation in either resident's record of staff contacting the family or physician and no documentation of the reason Resident #7 went to the emergency room. An interview was conducted with the Administrator on 1/27/26 at 12:15 PM. The Administrator stated the staff should have documented why the residents went to the hospital and notified the family and physician of the transfer for further care. The Administrator confirmed neither were documented. Class III	{A 025}		