

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 032                                                                 | <p>59A-36.007(7) FAC Resident Care - Elopement Standards</p> <p>59A-36.007<br/>(7) ELOPEMENT STANDARDS.</p> <p>(a) Residents Assessed at Risk for Elopement.<br/>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.</p> <p>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.</p> <p>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.</p> <p>(b) Facility Resident Elopement Response</p> | A 032                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 032                                                                 | <p>Continued From page 1</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. An immediate search of the facility and premises,</li> <li>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,</li> <li>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,</li> <li>4. The continued care of all residents within the facility in the event of an elopement.</li> </ol> <p>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and staff interview, the facility failed to conduct a minimum of two elopement drills each year that included the participation of all employees and the Administrator, for 2 of 2 years reviewed.</p> <p>The findings include:</p> <p>During an interview with the Administrator on 2/10/2026 at 12:20 PM, he was asked to provide the elopement drills conducted at the facility for the last 2 years. He stated he could not provide them. They had a different Administrative Assistant, and he did not know what she did with the elopement drills.</p> | A 032                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 032                                                                 | Continued From page 2<br><br>Review of facility records produced no evidence of elopement drills being conducted in the previous 2 years.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A 032                                                                          |                                                                                                                          |                          |                                                        |
| A 078                                                                 | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br><br>1. Evidence of a negative tuberculosis examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis.<br><br>2. If any staff member has, or is suspected of having, a communicable disease, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable disease. | A 078                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 078                                                                 | <p>Continued From page 3</p> <p>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(d) An assisted living facility contracting to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(f) Level 2 background screening must be conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on employee record review and staff interview, the facility failed to ensure within 30 days after beginning employment, 2 of 3 newly hired staff, Employee A and C, submitted a written statement from a health care provider documenting freedom from signs or symptoms of</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 078                                                                 | <p>Continued From page 4</p> <p>communicable disease, and failed to ensure 1 of 3 sampled employees, the Administrator, obtained annual documentation of a negative TB examination.</p> <p>The findings include:</p> <p>A. Record review for Employee A, hired 9/2/205, and Employee C, hired 9/12/2025 found no evidence of a written statement from a health care provider documenting that they did not have any signs or symptoms of communicable disease.</p> <p>The findings were confirmed during an interview with the Administrator on 2/10/2026 at 12:15 PM. He confirmed he did not have any documentation to provide.</p> <p>B. Record review of the employee file for the Administrator, hired 3/3/2022, found his most recent negative TB documentation was dated 7/18/2022.</p> <p>The findings were confirmed during an interview with the Administrator on 2/10/2026 at 12:15 PM. He confirmed he did not have evidence of a more recent TB screening.</p> <p>Class III</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |
| A 081                                                                 | <p>429.52(1 &amp; 7) FS; 59A-36.011(2-3) FAC Training - Staff In-Service</p> <p>429.52<br/>(1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A 081                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 081                                                                 | <p>Continued From page 5</p> <p>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.</p> <p>(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).</p> <p>(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).</p> <p>(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.</p> <p>59A-36.011<br/>(2) STAFF PRESERVICE ORIENTATION.<br/>(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously</p> | A 081                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 081                                                                 | <p>Continued From page 6</p> <p>completed core training as detailed in subsection (1).</p> <p>(b) New staff must complete the preservice orientation prior to interacting with residents.</p> <p>(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.</p> <p>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:</p> <ol style="list-style-type: none"> <li>1. Resident's rights; and,</li> <li>2. The facility's license type and services offered by the facility.</li> </ol> <p>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:</p> <p>(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 infection control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its infection control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement.</p> <p>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:</p> <ol style="list-style-type: none"> <li>1. Reporting adverse incidents.</li> <li>2. Facility emergency procedures including</li> </ol> | A 081                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 081                                                                 | <p>Continued From page 7</p> <p>chain-of-command and staff roles relating to emergency evacuation.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Resident rights in an assisted living facility.</li> <li>2. Recognizing and reporting resident abuse, neglect, and exploitation. The facility must use its abuse prevention policies and procedures when offering this training.</li> </ol> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Resident behavior and needs.</li> <li>2. Providing assistance with the activities of daily living.</li> </ol> <p>(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.</p> <p>(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.</p> <ol style="list-style-type: none"> <li>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.</li> <li>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.</li> </ol> | A 081                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 081                                                                 | <p>Continued From page 8</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on employee record review and staff interview, the facility failed to ensure 2 of 2 employees reviewed, Employee A and C, received a preservice orientation and training within the mandated timeframes. The facility also failed to ensure 1 of 2 employees reviewed, Employee C, received one hour of training in safe food handling.</p> <p>The findings include:</p> <p>Record review for Employee A, hired 9/2/2025 and Employee C, hired 9/12/2025, found no evidence they participated in a preservice orientation of at least 2 hours, or in infection control training.</p> <p>Further record reviews of the employee file for Employee A and C found no evidence the employees received training in resident rights; reporting abuse, neglect and exploitation; facility emergency procedures; incident reporting; or resident behavioral needs or providing assistance activities of daily living. Resident C also did not have evidence of one hour of training in safe food handling training.</p> <p>The findings were confirmed during an interview with the Administrator on 2/10/2026 at 12:15 PM. He was notified of the missing training. Evidence of the completed trainings was not provided.</p> <p>Class III</p> | A 081                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 082                                                                 | Continued From page 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A 082                                                                                            |                                                                                                                          |  |                                                        |
| A 082                                                                 | <p>59A-36.011(4) FAC Training - HIV/AIDS</p> <p>(4) HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on HIV and AIDS, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on employee record review and staff interview, the facility failed to ensure that 2 of 3 employees reviewed received training in Human Immunodeficiency/Acquired immune Deficiency Syndrome (HIV/AIDS) within 30 days of employment. (Employee A and C)</p> <p>The findings include:</p> <p>Record review for Employee A, hired 9/2/2025 and Employee C hired, 9/12/2025 found no evidence the employees received training in HIV/AIDS.</p> <p>During an interview with the Administrator on 2/10/2025 at 12:15 PM, he was notified evidence of the training was not in employee files. He confirmed he did not have evidence the employees had the training.</p> <p>Class III</p> | A 082                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 083                                                                 | Continued From page 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 083                                                                                            |                                                                                                                          |  |                                                        |
| A 083                                                                 | <p>59A-36.011(5) FAC Training - First Aid and CPR</p> <p>(5) FIRST AID AND CARDIOPULMONARY RESUSCITATION (CPR). A staff member who has completed courses in First Aid and CPR and holds a currently valid card documenting completion of such courses must be in the facility at all times.</p> <p>(a) Documentation that the staff member possess current CPR certification that requires the student to demonstrate, in person, that he or she is able to perform CPR and which is issued by an instructor or training provider that is approved to provide CPR training by the American Red Cross, the American Heart Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.</p> <p>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R.</p> <p>This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a staff member with current First Aid and cardiopulmonary resuscitation (CPR) training was always working in the facility to ensure the safety of the 9 residents that reside at the facility.</p> <p>The findings include:</p> <p>Record review of the Employee file for Employee A, hired 9/2/2025 and Employee C, hired 9/12/205, found no evidence of training in First Aid or CPR training.</p> | A 083                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 083                                                                 | Continued From page 11<br><br>During an interview with the Administrator on 2/10/2026 at 12:10 PM, he was asked if he had a system in place to ensure the facility always had someone in the facility with CPR and First Aid credentials. He stated each employee should provide proof of the training and it should be in their employee file. He confirmed it was not.<br><br>Record review of the employee schedule provided by the facility found only one employee scheduled to work from 7:00 PM to 7:00 AM. Employee C worked alone in the facility during the 7:00 PM to 7:00 AM shift and did not have proof of either training.<br><br>Class III                                                                                                                                                                                                                                                      | A 083                                                                          |                                                                                                                          |                          |                                                        |
| A 165                                                                 | 429.23(1-4 & 6-10) FS Risk Mgmt & QA<br><br>429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-<br>(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.<br>(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:<br>(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: | A 165                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 165                                                                 | Continued From page 12<br><br>1. Death;<br>2. Brain or spinal damage;<br>3. Permanent disfigurement;<br>4. Fracture or dislocation of bones or joints;<br>5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;<br>6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or<br>7. An event that is reported to law enforcement or its personnel for investigation; or<br>(b) Resident elopement, if the elopement places the resident at risk of harm or injury.<br>(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.<br>(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.<br>(6) Abuse, neglect, or exploitation must be reported to the Department of Children and Families as required under chapter 415.<br>(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, | A 165                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 165                                                                 | <p>Continued From page 13</p> <p>chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.</p> <p>(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.</p> <p>(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.</p> <p>(10) The agency may adopt rules necessary to administer this section.</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to document, investigate and file an adverse incident report for 1 of 2 residents that eloped from the facility. (Resident #1)</p> <p>The findings include:</p> | A 165                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 165                                                                 | <p>Continued From page 14</p> <p>During an interview with the Administrative Assistant on 2/20/2026 at 10:20 AM, she stated Resident #8 had eloped from the facility. During further interview with the Administrator Assistant on 2/10/2026 at 2:30 PM, one day before Christmas, a caregiver informed her Resident #1 had left the facility and went walking down the street. She knew that he should not leave the facility on his own, so she called the police to help find him. The police found him down the street getting ready to cross an intersection. The resident told the police he was going to a pawn shop. He could not remember where he lived or how to get back. The police informed Resident #1 they were looking for him and asked him to get in the car so they could take him back home. She stated Resident #1's daughter had informed the facility he should not be outside on his own due to his dementia and not knowing the area. The Administrative Assistant was asked if she had any written records about the elopement and she stated she did not.</p> <p>During an interview with the Administrator on 2/10/2026 at 1:03 PM, he was asked about Resident #1's elopement. He stated he did not do an adverse incident report. He stated the resident's care plan does not involve him leaving the facility. He stated Resident #1 was not supposed to leave the facility and went to the store. He stated he did not do an adverse incident report because other people go to the store.</p> <p>Class III</p> | A 165                                                                          |                                                                                                                          |  |                                                        |
| A 090                                                                 | <p>59A-36.011(11) FAC Training - Do Not Resuscitate Orders</p> <p>(11) DO NOT RESUSCITATE ORDERS</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A 090                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 090                                                                 | <p>Continued From page 15</p> <p><b>TRAINING.</b></p> <p>(a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders.</p> <p>(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding DNROs within 30 days after employment.</p> <p>(c) Training shall consist of the information included in rule 59A-36.009, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 sampled employees, Employee A and C, received training in Do Not Resuscitate Orders (DNROs) within 30 days of hire.</p> <p>The findings include:</p> <p>Record review for Employee A, hired 9/2/2025 and Employee C hired, 9/12/2025 found no evidence the employees received training in the facility's policies and procedures regarding DNROs.</p> <p>During an interview with the Administrator on 2/10/2025 at 12:15 PM, he was notified evidence of the training was not in employee's files. He confirmed he did not have evidence the employees had the training.</p> <p>Class III</p> | A 090                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 093                                                                 | Continued From page 16                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A 093                                                                          |                                                                                                                          |                          |                                                        |
| A 093                                                                 | 59A-36.012(2) FAC Food Service - Dietary Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at:<br><a href="http://www.frlrules.org/Gateway/reference.asp?No=Ref-04003">http://www.frlrules.org/Gateway/reference.asp?No=Ref-04003</a> , and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at:<br><a href="https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx">https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx</a> . Therapeutic diets must meet these nutritional standards to the extent possible.<br>(b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.<br>(c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of | A 093                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                          |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                           | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b>                                                                   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |
| A 093                                                                 | <p>Continued From page 17</p> <p>the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.</p> <p>1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.</p> <p>2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.</p> <p>(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.</p> <p>(e) Therapeutic diets must be prepared and served as ordered by the health care provider.</p> <p>1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.</p> <p>2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.</p> <p>(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.</p> | A 093                                                                                            |                                                                                                                          |
|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                          |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 093                                                                 | <p>Continued From page 18</p> <p>Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of calculating the time between meals.</p> <p>(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on hand.</p> <p>(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has contracted with residents to serve, must be on hand at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to log menu substitutions, and failed to maintain a 3-day food supply of nonperishable food for its 9 residents in the event of an emergency.</p> <p>The findings include:</p> <p>During dining observation on 02/10/2026 at 12:00 pm, residents were served baked chicken, scalloped potatoes, peas, and pudding.</p> | A 093                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 093                                                                 | <p>Continued From page 19</p> <p>Review of the facility's menu revealed they were on cycle two. The menu called for lunch on 2/10/2026 to be baked chicken, scallop potatoes, mixed salad, salad dressing, and pudding.</p> <p>Tour to the kitchen on 02/10/2026 at 12:30 pm revealed there was not a 3-day supply of emergency food items. Photographic evidence obtained.</p> <p>In an interview on 02/10/2026 at 12:45 pm, Employee B, Caregiver, confirmed that residents were not served the salad, instead they were served peas. When asked about substitution log and the emergency food, she stated that she was not sure where it was and mentioned that the Administrator might have it.</p> <p>Another tour was conducted on 02/10/26 at 1:56 pm with the Administrator. He confirmed that the facility did not have enough emergency food. He also confirmed that the facility did not have a substitution log.</p> <p>Class III</p> | A 093                                                                          |                                                                                                                          |  |                                                        |
| A 152                                                                 | <p>59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other</p> <p>(3) OTHER REQUIREMENTS.<br/>(a) All facilities must:</p> <ol style="list-style-type: none"> <li>1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;</li> <li>2. Be maintained free of hazards; and,</li> <li>3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A 152                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 152                                                                 | <p>Continued From page 20</p> <p>(b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:</p> <ol style="list-style-type: none"> <li>1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident,</li> <li>2. A closet or wardrobe space for hanging clothes,</li> <li>3. A dresser, chest or other furniture designed for storage of clothing or personal effects,</li> <li>4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,</li> <li>5. A comfortable chair, if requested.</li> </ol> <p>(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.</p> <p>(d) Residents who use portable bedside commodes must be provided with privacy during use.</p> <p>(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be threadbare.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain 3 of 4 emergency exit doors in good working order to ensure the safety of the 9 residents of the facility.</p> <p>The findings include:</p> <p>Observations in the facility with the Administrator on 2/10/2026 at 1:45 PM revealed the exit door on the north side of the facility did not</p> | A 152                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 152                                                                 | Continued From page 21<br><br>sound/alarm after opening. During the time of observation, the Administrator stated the door should sound after about 10 seconds. After at least a minute it still did not sound. The Administrator stated he would need to change the battery.<br><br>The door on the northwest side of the facility was checked next, and it made a very slight noise. The Administrator stated it was broken and he would need to get a new alarm. Observation of the alarm on the top of the door found the front of it was missing.<br><br>The door on the southwest side of the facility was checked next. It did not sound when opened. The Administrator stated he would need to get a new alarm for the door.<br><br>A sign was observed on the three doors that read, "Emergency Exit Only Security Alarm Will Sound If Door Is Opened."<br><br>Photographic evidence obtained.<br><br>Class III | A 152                                                                          |                                                                                                                          |  |                                                        |
| A 161                                                                 | 429.275(2) FS; 59A-36.015(2) FAC Records - Staff<br><br>429.275<br>(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | A 161                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 161                                                                 | <p>Continued From page 22</p> <p>licensure or certification is required under this part or rule.</p> <p>59A-36.015<br/>(2) STAFF RECORDS.<br/>(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable disease. In addition, records must contain the following, as applicable:</p> <ol style="list-style-type: none"> <li>1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C.,</li> <li>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,</li> <li>3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C.,</li> <li>4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C.,</li> <li>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.</li> </ol> <p>(b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C.</p> <p>(c) The facility must maintain the written work</p> | A 161                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 161                                                                 | Continued From page 23<br><br>schedules and staff time sheets for the most<br>current 6 months as required by Rule<br>59A-36.010, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on staff interview and record review, the<br>facility failed to maintain personnel records for 2<br>of 2 sampled employees, Employee A and C, that<br>included. a copy of the employment application,<br>with references furnished.<br><br>The findings include:<br><br>Record review of the employee files for Employee<br>A, hired 9/2/205 and Employee C, hired<br>9/12/2025, found no evidence of employment<br>references.<br><br>During an interview with the Administrator on<br>2/10/2026 at 12:00 PM, the findings were<br>confirmed. The Administrator stated they use the<br>same application for all staff, and it does not<br>include references.<br><br>Photographic evidence obtained.<br><br>Class III | A 161                                                                          |                                                                                                                          |                          |                                                        |
| A 162                                                                 | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records<br>must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. Sex,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A 162                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 162                                                                 | Continued From page 24<br><br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of<br>other health insurance carrier,<br>8. Name, address, and telephone number of next<br>of kin, legal representative, or individual<br>designated by the resident for notification in case<br>of an emergency; and,<br>9. Name, address, and telephone number of the<br>resident's health care practitioner and case<br>manager, if applicable.<br>(b) A copy of the Resident Health Assessment<br>form, AHCA Form 1823 or the health care<br>practitioner's medical examination form described<br>in Rule 59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services,<br>therapeutic diets, do not resuscitate orders, or<br>other services to be provided, supervised, or<br>implemented by the facility that require a health<br>care provider's order.<br>(d) Documentation of a resident's refusal of a<br>therapeutic diet pursuant to Rule 59A-36.012,<br>F.A.C., if applicable.<br>(e) The resident care record described in<br>paragraph 59A-36.007(1)(f), F.A.C.<br>(f) A weight record that is initiated on admission.<br>Information may be taken from AHCA Form 1823<br>or the resident's health assessment. Residents<br>receiving assistance with the activities of daily<br>living must have their weight recorded<br>semi-annually. This subsection does not apply to<br>residents who are receiving licensed hospice<br>services when such residents, their<br>representatives, or their physicians request in<br>writing that weights not be taken.<br>(g) For facilities that will have unlicensed staff<br>assisting the resident with the self-administration<br>of medication, a copy of the written informed<br>consent described in Rule 59A-36.006, F.A.C., if<br>such consent is not included in the resident's | A 162                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 162                                                                 | Continued From page 25<br><br>contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.<br>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.<br>(l) If the resident is an OSS recipient, a copy of the Department of Children and Families form Alternate Care Certification for Optional State Supplementation (OSS), CF-ES 1006, October 2005, which is hereby incorporated by reference and available for review at:<br><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a> . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.<br>(m) Documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.<br>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, | A 162                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 162                                                                 | <p>Continued From page 26</p> <p>F.A.C.</p> <p>(o) The resident's Do Not Resuscitate Order, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement.</p> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a weight record for 2 of 2 sampled residents ( #4 and #9).</p> <p>The findings include:</p> <p>Record review revealed that Resident #4 was admitted to the facility on 4/1/22 and Resident #9 was admitted 4/29/21. Further review revealed that they had not weights taken after admission.</p> <p>In an interview on 02/10/26 at 3:00 pm, Employee A, Medication Technician, confirmed that there were no weight records for these residents. She</p> | A 162                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11696315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 162                                                                 | Continued From page 27<br><br>added that the facility did not have a working<br>scale.<br><br>During interview with the Administrator on<br>01/20/26 at 3:07 pm, he stated that residents<br>weights should be obtained monthly. He stated<br>that he and the Administrative Assistant were<br>responsible for taking the weights. When asked if<br>weights had been taken, he said she was not<br>sure if it was done.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A 162                                                                          |                                                                                                                          |  |                                                        |
| ZZB14                                                                 | 435.12(2)(b-d), FS Background Screening<br>Clearinghouse<br><br>435.12 Care Provider Background Screening<br>Clearinghouse.-<br>(2)(b) Until such time as the fingerprints are<br>enrolled in the national retained print arrest<br>notification program at the Federal Bureau of<br>Investigation:<br>1. A person with a break in service of more than<br>90 days from a position that requires screening<br>by a specified agency must submit to a national<br>screening if the person returns to a position that<br>requires screening by a specified agency.<br>2. Effective January 1, 2026, or a later date as<br>determined by the Agency for Health Care<br>Administration, for the participation of qualified<br>entities in the clearinghouse under s. 435.12, a<br>person with a break in service of more than 90<br>days from a position for which screening is<br>conducted by a qualified entity participating in the<br>clearinghouse must submit to a national<br>screening if the person returns to a position for<br>which screening is conducted by a qualified<br>entity.<br>(c) An employer of persons subject to screening | ZZB14                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CROWN ASSISTED LIVING, LLC**

**301 MILFORD PLACE  
NEW SMYRNA BEACH, FL 32168**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| ZZ814                    | <p>Continued From page 28</p> <p>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.</p> <p>1. Before January 1, 2024, 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.</p> <p>2. Effective January 1, 2024, 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.</p> <p>(d) An employer or a qualified entity participating in the clearinghouse must register with and 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 fingerprint 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; sex; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on employee record review and staff interview, the facility failed to ensure 2 of 3 employees, Employee A and C, were added to their roster within 5 days of employment.</p> <p>The findings include:</p> | ZZ814               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ814                                                                 | Continued From page 29<br><br>Record review of the background screening provided by the facility for Employee A, hired 9/2/205, and Employee C, hired 9/12/2025, found no evidence they were added to the facility's AHCA Clearinghouse Roster after employment.<br><br>Record review of the Employee/Contractor Roster provided by the facility revealed neither employees were listed.<br><br>The Administrator was notified that Employee A was not added. He left and returned at 11:40 AM on 2/10/2026 with a new printout that had Employee A listed. He stated he just added her.<br><br>Further review of the Agency for Health Care Administrator Background screening system revealed Employee A and C were not added until the survey on 2/10/2026.<br><br>Photographic evidence obtained.<br><br>Unclassified. | ZZ814                                                                          |                                                                                                                          |  |                                                        |
| ZZ816                                                                 | 408.809(2) 435.05(2) 59A-35.090(2d-3b)<br>Background Screening-Compliance Attestation<br><br>408.809 Background screening; prohibited offenses. -<br>(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law                                                                                                                                                                                                                                 | ZZ816                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ816                                                                 | Continued From page 30<br><br>Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:<br>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;<br>(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and | ZZ816                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ816                                                                 | <p>Continued From page 31</p> <p>(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.</p> <p>435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:</p> <p>(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.</p> <p>59A-35.090 Background Screening.</p> <p>(d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, July 2024, herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if arrested for any disqualifying offense. The Attestation of Compliance is available at <a href="https://www.flrules.org/Gateway/reference.asp?No=Ref-17724">https://www.flrules.org/Gateway/reference.asp?No=Ref-17724</a>, and available from the Agency for Health Care Administration's website at: <a href="https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations">https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations</a>.</p> <p>(e) An administrator or chief financial officer must be screened and qualified prior to appointment to the position.</p> <p>(3) Results of Screening and Notification.</p> | ZZ816                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| ZZ816                                                                 | <p>Continued From page 32</p> <p>(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: <a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">apps.ahca.myflorida.com/SingleSignOnPortal</a>.</p> <p>(b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the arrest report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on employee record review and staff interview, the facility failed to ensure 3 of 3 employees reviewed (Administrator, Employee A and C) completed and signed the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008.</p> <p>The findings include,</p> <p>Record review of the employee files for Employee A, hired 9/2/2025, Employee C, hired 9/12/2025 and for the Administrator, hired 3/3/2022, found no evidence of the Attestation Form 3100-0008 in the records.</p> <p>During an interview with the Administrator on 2/10/2025 at 12:05 PM, he was asked if he could locate the Attestations. He confirmed he could not.</p> | ZZ816                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ816                                                                 | Continued From page 33<br><br>Unclassified                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ZZ816                                                                          |                                                                                                                          |  |                                                        |
| ZZ830                                                                 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning;<br>emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes<br>and agency rule to have a comprehensive<br>emergency management plan must designate a<br>safety liaison to serve as the primary contact for<br>emergency operations. Such licensee shall<br>submit its comprehensive emergency<br>management plan to the local emergency<br>management agency, county health department,<br>or Department of Health as follows:<br>(a) Submit the plan within 30 days after initial<br>licensure and change of ownership, and notify the<br>agency within 30 days after submission of the<br>plan.<br>(b) Submit the plan annually and within 30 days<br>after any significant modification, as defined by<br>agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30<br>days after notification that plan revisions are<br>required.<br>(d) Notify the agency within 30 days after<br>approval of its plan by the local emergency<br>management agency, county health department,<br>or Department of Health.<br>(2) An entity subject to this part may temporarily<br>exceed its licensed capacity to act as a receiving<br>provider in accordance with an approved<br>comprehensive emergency management plan for<br>up to 15 days. While in an overcapacity status,<br>each provider must furnish or arrange for<br>appropriate care and services to all clients. In<br>addition, the agency may approve requests for<br>overcapacity in excess of 15 days, which<br>approvals may be based upon satisfactory | ZZ830                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| ZZ830                                                                 | Continued From page 34<br><br>justification and need as provided by the receiving and sending providers.<br>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:<br>1. Suffered damage to its operation during the state of emergency.<br>2. Is currently licensed.<br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<br>(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and | ZZ830                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ830                                                                 | <p>Continued From page 35</p> <p>applicable rules and statutes.</p> <p>(4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their comprehensive emergency management plan (CEMP), applicable to all residents of the facility, to the local agency for review on and annual basis.</p> <p>Findings Included:</p> <p>A review of the facility's CEMP, on 2/10/26, revealed the last approval from the local reviewing agency was dated 9/16/24.</p> <p>In an interview with the Administrator at 2:20pm on 2/10/26, he stated that they recently received the Fire Marshall approval and he had not yet submitted his 2026 CEMP because he still is waiting on getting a signed evacuation host agreement. He stated knew that it was late.</p> <p>Class III</p> | ZZ830                                                                          |                                                                                                                          |  |                                                        |
| ZZ875                                                                 | <p>430.5025(4 &amp; 7-9) Alzheimer disease/dementia; Training</p> <p>(4) Employees of covered providers must complete the following training for Alzheimer's disease and related forms of dementia:</p> <p>(a) Upon beginning employment, each employee must receive basic written information about</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ZZ875                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| ZZ875                                                                 | <p>Continued From page 36</p> <p>interacting with persons who have Alzheimer's disease or related forms of dementia.</p> <p>(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.</p> <p>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 dementia, how to identify the signs and symptoms of dementia, and skills for communicating and interacting with persons with Alzheimer ' s disease or related forms of dementia. 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.</p> <p>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.</p> <p>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.</p> <p>(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</p> | ZZ875                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ875                                                                 | Continued From page 37<br><br>skills in working with families and caregivers.<br>(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.<br>(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 Alzheimer's disease or related forms of dementia, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:<br>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).<br>2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of dementia-specific training. Such training must include, but is not limited to, understanding Alzheimer's disease and related forms of dementia, the stages of Alzheimer's disease, communication strategies, medical information, and stress management.<br>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 technology. For this | ZZ875                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                                                                                                                          |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                           |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| ZZ875                                                                 | <p>Continued From page 38</p> <p>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 hands-on experience to help develop and refine the employee's skills for caring for a person with Alzheimer's disease or a related form of dementia. The continuing education must cover at least one of the topics included in the dementia-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 technology chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.</p> <p>(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.</p> <p>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.</p> <p>(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.</p> <p>(8) For a health care practitioner as defined in s.</p> | ZZ875                                                                                            |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ875                                                                 | <p>Continued From page 39</p> <p>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.</p> <p>(9) Each person employed, contracted, or referred to provide services before July 1, 2023, must complete the training required in this section before July 1, 2026. Proof of completion of equivalent training completed before July 1, 2023, shall substitute for the training required in subsection (4). Each person employed, contracted, or referred to provide services on or after July 1, 2023, may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6).</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 2 of 2 staff members sampled that provided personal care to residents completed a 1-hour training related to Alzheimer's and Dementia within 30 days after beginning employment. (Employee A and C)</p> <p>The findings include:</p> <p>Record review of the employee file for Employee A, hired 9/2/2025, and Employee C, hired 9/12/2025, found no evidence either employee completed the 1-hour video of Alzheimer's training.</p> <p>The findings were confirmed during an interview with the Administrator on 2/10/2025 at 12:15 PM. He was informed the training was missing from the employee files. He did not have any further evidence to provide.</p> | ZZ875                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| ZZ875                                                                 | Continued From page 40<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ZZ875                                                                                            |                                                                                                                          |  |                                                        |
| A 000                                                                 | Initial Comments<br><br>A relicensure survey and complaint investigation<br>(complaint numbers 2025007013, 2025010114,<br>2026001632 ) was conducted at Crown Assisted<br>Living on February 10, 2026.<br><br>The facility had deficiencies at the time of the<br>investigation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 000                                                                                            |                                                                                                                          |  |                                                        |
| A 008                                                                 | 429.26(5-6) FS; 59A-36.006(2) FAC Admissions -<br>Health Assessment<br><br>429.26<br>(5) Each resident must have been examined by a<br>licensed physician, a licensed physician<br>assistant, or a licensed advanced practice<br>registered nurse within 60 days before admission<br>to the facility or within 30 days after admission to<br>the facility, except as provided in s. 429.07. The<br>information from the medical examination must<br>be recorded on the practitioner's form or on a<br>form adopted by agency rule. The medical<br>examination form, signed only by the practitioner,<br>must be submitted to the owner or administrator<br>of the facility, who shall use the information<br>contained therein to assist in the determination of<br>the appropriateness of the resident's admission<br>to or continued residency in the facility. The<br>medical examination form may only be used to<br>record the practitioner's direct observation of the<br>patient at the time of examination and must<br>include the patient's medical history. Such form<br>does not guarantee admission to, continued<br>residency in, or the delivery of services at the<br>facility and must be used only as an informative<br>tool to assist in the determination of the | A 008                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 008                                                                 | <p>Continued From page 41</p> <p>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 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.</p> <p>(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 psychiatric 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</p> | A 008                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 008                                                                 | <p>Continued From page 42</p> <p>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 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 optional state supplementation require such assistance.</p> <p>59A-36.006</p> <p>(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,</li> <li>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,</li> <li>3. Any nursing or therapy services required by the individual,</li> <li>4. Any special diet required by the individual,</li> <li>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,</li> </ol> | A 008                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                                                                                                                          |                                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                           |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 008                                                                 | <p>Continued From page 43</p> <p>6. Whether the individual has signs or symptoms of Tuberculosis, Methicillin Resistant Staphylococcus Aureus, Scabies or any other communicable disease, which are likely to be transmitted to other residents or staff,</p> <p>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,</p> <p>8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner.</p> <p>(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, April 2021, which is incorporated by reference and available online at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-13531">http://www.flrules.org/Gateway/reference.asp?No=Ref-13531</a>. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed.</p> <p>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.</p> <p>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.</p> | A 008                                                                                            |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 008                                                                 | <p>Continued From page 44</p> <p>(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).</p> <p>(d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule.</p> <p>(e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, therapy, or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Do Not Resuscitate Order Form, for residents who do not wish cardiopulmonary resuscitation to be administered in the case of cardiac or respiratory arrest.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and staff interview, the facility failed to obtain a health assessment for 1</p> | A 008                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                          |  |                                                        |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 008                                                                 | Continued From page 45<br><br>of 3 residents reviewed. (Resident #1)<br><br>The findings include:<br><br>Facility records showed Resident #1 was<br>admitted on 6/1/2025. Review of Resident #1's<br>record found no 1823 health assessment. The<br>findings were confirmed during an interview with<br>the Administrator's Assistant on 2/10/2026 at 2:30<br>PM.<br><br>On 2/10/2026 at 3:09 PM, the Administrator also<br>confirmed the facility did not have a health<br>assessment for the resident. He was given the<br>resident file to look through and could not find<br>one.<br><br>Class III                                                                                                                                                                                                                                                                                                             | A 008                                                                                            |                                                                                                                          |  |                                                        |
| A 026                                                                 | 59A-36.007(2) FAC Resident Care - Social &<br>Leisure Activities<br><br>(2) SOCIAL AND LEISURE ACTIVITIES.<br>Residents shall be encouraged to participate in<br>social, recreational, educational and other<br>activities within the facility and the community.<br>(a) The facility must provide an ongoing activities<br>program. The program must provide diversified<br>individual and group activities in keeping with<br>each resident's needs, abilities, and interests.<br>(b) The facility must consult with the residents in<br>selecting, planning, and scheduling activities. The<br>facility must demonstrate residents' participation<br>through one or more of the following methods:<br>resident meetings, committees, a resident<br>council, a monitored suggestion box, group<br>discussions, questionnaires, or any other form of<br>communication appropriate to the size of the<br>facility. | A 026                                                                                            |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 026                                                                 | <p>Continued From page 46</p> <p>(c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate.</p> <p>(d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and interview, the facility failed to provide evidence of a diverse activity program available 6 days a week of a total of 12 hours or more for the 9 residents of the facility.</p> <p>The findings include:</p> <p>Observations made during a tour of the facility on 10/10/2026 at 9:20 AM, found no evidence of an activity calendar.</p> <p>During an interview with Employee A on 2/10/2026 at 10:10 AM, she was asked where the facility activity calendar was located. She stated it should be on the bulletin board. She left the medication room and returned and stated it must have been taken down.</p> <p>During an interview with the Administrator's</p> | A 026                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966315</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/10/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CROWN ASSISTED LIVING, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 MILFORD PLACE<br/>NEW SMYRNA BEACH, FL 32168</b>                         |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 026                                                                 | <p>Continued From page 47</p> <p>Assistant on 2/10/2026 at 10:45 AM she was asked if she knew what happened to the activity calendar and she stated she did not have it up.</p> <p>During tour on 01/20/2026 at 9:50 am, Resident#2 was observed in her room. She was clean and well groomed. She mentioned that she had been in the facility for 2 years . She stated that the facility only had 2 activities a month (Bingo and live music once a month). She added that she would like to have more activities.</p> <p>On 02/10/2026 at 10:02 am, Resident #4 stated that she has been in the facility for almost 5 years. She also mentioned that the facility only has two activities a month (a couple that visited every 2 weeks and does Bingo, and another lady that does live music once month). She stated that she would like more activities.</p> <p>Class III</p> | A 026                                                                          |                                                                                                                          |                          |                                                        |