Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969935	A. BUILDING: _____ B. WING _____	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAKE AT HAMLIN, THE	4814 HAMLIN GROVE TRL WINTER GARDEN, FL 34787

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
ZZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

AHCA Form 3020-0001

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

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821		

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ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to electronically submit a day 1 adverse incident and a full 15-day adverse incident report to the agency for 2 of 5 sampled residents (#3, #5) for with injury and required a higher acuity level of care (hospital).	ZZ821		

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ZZ821	Continued From page 4 Findings: 1. A review of resident #3's record revealed date of admission . The last 1823 Health Assessment dated listed medical history of , , and sleep , . He is only alert and oriented to himself. He needed supervision in activities of daily living (ADLs) with bathing and . He needs assistance with self-administration of medications. A facility note dated at 12:26 PM, resident #3 and found sitting on the edge of his bed on the floor hitting his on right side. Resident #3 was not wearing his non-slid socks. 911 was called and resident #3 was taken to the hospital. The physician and family were notified. A facility note dated at 5:16 PM, resident #3 returned from the hospital with a hematoma on his and did not require surgery. There was no documented evidence that the facility submitted the adverse incident to the agency. On at 9:47 AM, an interview with the Director of Wellness confirmed the findings. (Photographic Evidence Obtained) 2. Review of resident #5's record revealed an admission date on . A 1823 health assessment indicated a medical history of , , , use of wheelchair, walker, identified as a risk, require assistance with all activities of daily living, and receiving hospice	ZZ821		

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ZZ821	Continued From page 5 services. On at 9:30 AM, a facility note indicated resident #5 had an unwitnessed and was found by personal assistant B on the floor in front of the toilet in her apartment. Approximately 20 minutes later, resident reported mild lower . . . , with movement, , and , discomfort. Resident was observed touching her . Emergency Medical Service ( ) called, and the resident transported to hospital. On at 2:33 PM, the Administrator was asked to provide the incident report submitted to the agency for resident #5's and transport to a higher level of care. On at 2:39 PM, the Administrator stated after she spoke with the Director of Wellness, they did not submit an incident report for the . On at approximately 2:45 PM, the Director of Wellness stated she did not submit for the . Further stating, the facility has not been submitted for every . Unclassified	ZZ821		
ZZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living	ZZ841		

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ZZ841	Continued From page 6 facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with	ZZ841		

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family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support.
3. The resident, client, or patient is making one or more major medical decisions.
4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently .
5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
6. A resident, client, or patient who used to talk and interact with others is seldom speaking.
7. For hospitals, childbirth, including labor and delivery.
8. patients.
(d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures.
(e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request.
(f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites.

This Statute or Rule is not met as evidenced by:
Based on interview, record review, and review of the facility's website, the facility failed to make its visitation policies and procedures easily

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ZZ841	Continued From page 8 accessible from the homepage of their website. Findings: Review of the facility's website revealed its visitation policies and procedures were not on it. During an interview on at 2:40 PM, the Administrator confirmed the findings. Class III	ZZ841		
A 000	Initial Comments A re-licensure survey, a complaint investigation (2026001508,) and a generator monitoring were conducted at The Blake at Hamlin on and . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of	A 010		

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A 010	Continued From page 9	A 010		

appropriateness for admission and continued residency of an individual in a facility:
(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.
(b) A facility may admit or retain a resident who requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended

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A 010	Continued From page 10 congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued	A 010		

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A 010	Continued From page 11 residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of	A 010		

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placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.
(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to obtain a new 1823 Health Assessment or to medical examination by a healthcare provider for continued residency after a significant change for 1 of 5 sampled residents (#3) as required.

Findings:

A review of resident #3's record revealed date of admission . The last 1823 Health Assessment dated listed medical history of , , , and sleep , . He is only alert and oriented to himself. He needed supervision in activities of daily living (ADLs) with bathing and . He needs assistance with self-administration of medications.

A facility note dated at 12:26 PM, resident #3 and found sitting on the edge of his bed on the floor hitting his on right side. Resident #3 was not wearing his non-slid socks.

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A 010	Continued From page 13 911 was called and the resident was taken to the hospital. The physician and family were notified. A facility note dated at 5:16 PM, resident #3 returned from the hospital with a hematoma on his and did not require surgery. There was no new 1823 Health Assessment completed by the healthcare provider for significant change, indicating now he is a risk. In further review, resident #3 became with and requiring him to wear consumable adult briefs and resident #3 has severe agitation, combative and aggressive behaviors. On at 9:47 AM, an interview with the Director of Wellness confirmed the findings. On at 11:10 AM, an interview with the Administrator confirmed that she was aware that a new 1823 Health Assessment was not completed by a healthcare provider after resident #3 on . (Photographic Evidence Obtained) Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to	A 025		

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A 025	Continued From page 14 such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian,	A 025		

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A 025	Continued From page 15 health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for with injuries for 1 of 5 sampled residents (#5), failed to provide adequate supervision to 1 of 5 sampled residents who was aggressive towards others (#3,) and failed to ensure a health care provider's order was followed by not ensuring the , and rate were checked prior to giving a medication to 1 of 5 sampled residents (#1.) Findings: Review of resident #1's record revealed a medical history of , . Review of resident #1's , MOR (Medication Observation Record) revealed an entry for , 25 milligrams extended release take one tablet by once daily hold for . less than or . There was no documentation on either the MOR or in the resident's record to indicate the resident's , and rate were checked before administering the	A 025		

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A 025	Continued From page 16 medication on and . During an interview on at 2 PM, the Director of Wellness said there was no documentation to indicate the , and rate were checked. 2. Review of resident #5's record revealed an admission date on . A 1823 health assessment indicated a medical history of , , , use of wheelchair, walker, identified as a risk, requires assistance with all activities of daily living, and receiving hospice services. An incident report dated indicated of of bones or joints. 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. A hospital report dated indicated reason for visit , , , closed of of right pubis. On at 11:46 AM, a facility note indicated resident was seen by hospice on due to recent , noted to left arm and left side of . On at 12:33 AM, a facility note indicated the resident has overnight private caregiver. On at 3:40 PM, a facility note indicated resident family is canceling sitter, staff to continue to frequent checks and engage resident in activities.	A 025		

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A 025	Continued From page 17 On at 11:56 AM, a facility note indicated hospice nurse called to evaluate resident. The resident has 5m prn (as needed) for On at 10:12 AM, a facility note indicated hospice nurse visited to evaluate resident for medication changes for and to deliver recliner wheelchair. On at 10:00 AM, a facility note indicated staff were rounding and observed the resident on floor next to bed. Resident observed to have non-slip socks on. to left and soiled brief. A facility incident report dated at 9:00 AM, indicated incident type from bed, reported staff was rounding and observed resident on floor next to bed. On at 7:00 AM, a facility note indicated resident returned to community, discharged stated resident sustained closed of of right pubis. On at 11:08 PM, a facility note indicated hospice arrived to assess resident and resident was transferred to hospital. A facility incident report dated at 11:08 PM, indicated incident type ; observed resident laying in a right lateral side position on the floor near the apartment door. On at 10:49 PM, a facility note indicated hospice nurse arrived to assess resident and does not require transfer to hospital.	A 025		

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A 025	Continued From page 18 On at 9:39 PM, a facility note indicated the resident had an unwitnessed ; nurse assessed resident and no injuries noted. A facility incident report dated at 9:15 PM, indicated incident type from bed; resident observed lying supine, assistive device noted to be away from resident. On at 1:15 AM, a facility note indicated resident observed lying on her left lateral side on the floor of her apartment near bathroom. Walker was beside the resident. Upon assessment, observed raised hematoma noted on right side of occipital region. noted on left , resident complained of . in the right and right , . On at 12:48 PM, a facility note indicated resident was seen by hospice. On at 8:18 AM, a facility note indicated resident was seen by hospice on for initial admission. On at 11:10 PM, a facility note indicated will be checked regularly to ensure comfort and safety. On at 8:00 PM, a facility note indicated resident returned to facility via transport. The resident is now on hospice for diagnosis of . On at 12:47 PM, a facility note indicated continued , . On at 12:44 PM, a facility note indicated the resident complained of , , no relief from , , resident unable to sit still, called	A 025		

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A 025	Continued From page 19 911 to transport. On at 4:15 PM, a facility note indicated the resident complained of lower , . On at 12:10 PM, a facility note indicated the resident is still complaining of , . On at 2:32 PM, a facility note indicated the resident's family member is concerned with the resident's for over 10 years. On at 12:40 PM, a facility note indicated visited resident as hospital, has no findings of collapsed . On at 10:59 AM, a facility note indicated resident admitted for collapsed . On at 11:00 AM, a facility note indicated informed primary of and hospital resident was transferred to. On at 9:30 AM, a facility note indicated resident had an unwitnessed and was found by personal assistant B on the floor in front of the toilet in her apartment, without pants on and unable to state how long she had been on the floor. A facility incident report dated at 9:30 AM, indicated incident type , resident had an unwitnessed and was observed by PA on the floor in front of the toilet in her apartment without pants on and unable to state how long she had been on the floor. On at 10:59 AM, Caregiver B stated the on the 24th happened after her shift. Adding, when resident #5 is in her room she does not	A 025		

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A 025	Continued From page 20 have a call button to ask for help. Further stating, when she does her rounds resident #5 does not always need to use the bathroom and will get up after they leave the room. Caregiver B stated since the last they ensure someone is always on the floor with the residents if they have to take another resident to be changed. Adding, resident #5 she is kept close to the staff which seems to be working, and they tell the resident it's for her safety. On at 11:59 AM, LPN E stated she was not present during resident #5's first on . Adding, it was an unwitnessed , and the resident was found in the bathroom with her pants down by the personal assistant. Further stating, the resident was unable to tell them how long she had been down and stated she was , so they sent her to the hospital. LPN E stated she was unaware resident #5 had 2 on and was only aware of the 1 which resulted in injury. LPN E added, since the last resident #5's family brought the high wheelchair which seems to help and the staff does more frequent checks keeping the resident in the common area. On at 3:24 PM, LPN R stated she had only been working for 2 - 3 days at the facility and was training when resident #5 had the first on . Adding, there were 2 working but does not know their names. Further stating, they came to get her to inform her that resident #5 was found on the floor, an unwitnessed . The resident was checked, found no injuries and put in bed. LPN R stated after the hospice nurse came and left another staff member heard resident #5 yelling and found her on the floor having a second . Another hospice nurse came out, and the resident was sent out to the	A 025		

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A 025	Continued From page 21 hospital. On at 3:32 PM, the Memory Care Director stated she did not assess resident #5 prior to moving in. Adding, resident #5 walked with a walker during admission and was supposed to be kept in the common area. Further stating, she was not present during resident #5's as they occurred in the morning, and the family paid for a private sitter. The Memory Care Director stated resident #5 is now on hospice and they are to continue monitoring and to keep her out in the common area. Adding, she thinks resident #5 needs a lower bed and the one she has is too high. Review of the facility's dated Prevention & Intervention policy stated The Director of Wellness and the Executive Director / Administrator are responsible for implementing prevention strategies. prevention begins at the time of the initial assessment and admission. New memory care residents will be closely observed through frequent safety checks during the first 72 hours post-admission to evaluate patterns, identify potential risks, and adjust care plans accordingly. Identify any environmental factors that may have contributed to the . Implement positive interventions to reduce the risk of any environmental factors that may have contributed to the . The resident should be able to sit on the edge of the bed with his or her resting firmly on the floor. On at 8:52 AM, observation of resident #5's bed appeared to be an approximate of 1 - 2 from the mattress to the floor. On at 8:56 AM, Caregiver B stated resident #5 requires assistance to get in and out	A 025		

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A 025	Continued From page 22	A 025		

of bed as her bed is too high. Further stating, her cannot touch the floor when sitting on the side of the bed and she rests them on the bed rail. Adding, she was present when resident #5 on . Further stated, resident #5 does not have a call pendant on her or near the bed. There is only a pull cord in the bathroom, and the resident requires assistance to use the bathroom.

Review of resident #5's service plan indicated toileting - resident needs {frequent /assist with brief changes).

On at 11:13 AM, the Director of Wellness stated they do frequent checks on resident #5 and the resident has when asked what interventions and preventive measures were put in place, being that the resident was identified as a risk upon admission. After the Director of Wellness reviewed the 11/29/25 admission 1823, specifically to the ADLs which stated needs supervision with toileting. She stated she did not do the assessment, and the ADLs were documented by someone else, who was identified as A Registered Nurse Practitioner. The Director of Wellness was asked about the prevention policy which speaks to "the resident should be able to sit on the edge of the bed with his or her resting firmly on the floor" and the of the current bed. She stated the facility has requested a hospital bed but not sure why that's not here yet and will follow up with hospice. The Director of Wellness was asked to provide a copy of the request, but no documentation was provided.

On at 11:30 AM, the Administrator stated she was aware of resident #5's four . Further stating, the Director of Wellness is getting the

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A 025	Continued From page 23 order for the lower bed and confirmed they did not have one. Adding, she thought hospice would have taken care of that. On at 1:44 PM, the responsible party of resident #5 during a phone call stated she was aware of resident #5's 4 since her admission to the facility. Adding, she has no concerns with the facility and that resident #5 was a risk before moving into the facility and she made the facility aware. 3. A review of resident #3's record revealed date of admission . The last 1823 Health Assessment dated listed medical history of , , , and sleep , . He is only alert and oriented to himself. He needed supervision in activities of daily living (ADLs) with bathing and . He needs assistance with self-administration of medications. A facility note dated at 12:26 PM, resident #3 and found sitting on the edge of his bed on the floor hitting his on right side. Resident #3 was not wearing his non-slid socks. 911 was called and the resident was taken to the hospital. The physician and family were notified. A facility note dated at 5:16 PM, resident #3 returned from the hospital with a hematoma on his and did not require surgery. A review of resident #3's service plan dated and not signed by resident #3, or legal representative and the Administrator. In further review, service plan was not implemented until two days after his ( ) resulting in injury of a hematoma on his and not being follow by the facility.	A 025		

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A 025	Continued From page 24 1. the service plan did not document monitoring for daily checks for especially getting in/out of bed. There was no duration time, documented as 0.00. 2. the service plan did not document or did not indicate interventions put in place for resident #3 such as non-skid socks, assistive device, emergency response pendant, adjusting medications and other tools needed for him that is a high risk for . 3. the service plan documented behavioral management with maintaining appropriate behavior in a social setting and checking twice daily every day. The facility could not provide any documentation that this was being done. A review of multiple facility notes below provided a timeframe from resident 3's admission to current that documented his severity of agitation, aggression, and combative behaviors toward both staff and other residents residing in the Memory Care. On at 11:04 AM by Licensed Practical Nurse (LPN) O documented resident #3 refused to take his medications during this shift. Attempted two more times to give to resident #3 but he refused both times. I left the medication in a cup on his night table in his room. Went to check on resident #3 and saw the medications thrown away in the trash can. When asked if he would like to take his medication, resident #3 became agitated and started slamming his door to the bathroom and told staff to get out of his room balling up his fist attempting to hit me.	A 025		

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A 025	Continued From page 25 On at 7:16 PM by LPN K documented resident #3 had a behavior today, he broke a window into pieces. He was not injured and staff redirected him to the dining room for a snack. On at 5:07 PM by LPN N documented resident #3 went to a female's resident room and the female resident had to push resident #3 out of her room. The female resident said that she was very nervous because resident #3 was very strong and she knows he gets mad, but he left her room without incident. On at 10:19 AM by LPN N documented resident #3 had disruptive behaviors as he throwing things in his rooms. He went into the hallway shoving the community furniture. He was observed trying to pull the rails off the walls in the hallway. Attempted to give him as needed , but he refused. The private caregiver was trying to redirect him but unsuccessful. Resident #3 shoved the private caregiver. An attempt telephone call to son, but no answer. Left a voicemail message. On at 6:29 PM by Director of Wellness documented that the physician was at the facility to visit resident #3. The doctor decreased , due to increase and ongoing . On at 3:26 PM by LPN N documented resident #3 had several incidents today. He entered another resident's room. Resident #3 made it out of the Memory Care unit into the lobby up front when a visitor opened the door coming into the Memory Care unit. Resident #3 was agitated and unable to redirect him. Notified his physician regarding his behavior.	A 025		

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A 025	Continued From page 26 On at 2:38 AM nurse L documented that resident #3 was attempting to go into another resident room. Will continue to observe behaviors. On at 9:33 PM by Director of Wellness documented observed resident #3 in the dining room looking through staff lunch bags. He picked up a baby doll belonging to another resident and threw it at another resident, hitting her in the left . . Redirected him to his room and gave him apple sauce. On at 5:15 PM by LPN N documented resident #3 kept being exit seeking and kept going into other resident's rooms. Resident #3 was being aggressive and throwing objects at staff. On at 10:19 PM by LPN L documented tried to shower resident #3 but he was very aggressive, combative and toward staff and the private sitter to let him assist him. Contact the son and the son said to just leave him be and have the private sitter to try again later and if he continues to be and combative to just let the morning staff deal with it. On at 8:33 AM by Director of Wellness documented called hotline at 8:20 AM to report an incident regarding to last night report, the report was accepted. An interview on at 9:45 AM with the Director of Wellness confirmed that she did not complete an internal investigation and did not document the details and reason why the hotline was called. She explained that it was reported to her that one of the private caregiver hit resident #3.	A 025		

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A 025	Continued From page 27 On at 9:15 PM by Director of Wellness documented it was reported that resident #3 was walking around with his son and resident #3 threw his shoe at Director of Wellness and another resident earlier in the day at 3 PM. On at 3:45 PM by LPN K documented that the sitter told resident #5 to sit down in the dining room to eat his meal and resident #3 spit in the sitter's . Nurse redirected resident #3 to his bedroom. The son was called to inform about resident #3's behaviors. On at 7:30 PM by LPN K documented that resident #3 sitter reported that he had spit on her . The sitter informed the facility and called his son about his behavior. Left a message. On at 8:30 PM by LPN K documented resident #3 was walking in the hallway with his sitter and he had increased agitation, screaming and shouting at everyone. Redirected him and gave him as needed , , he finally calmed down. On at 4:11 PM by Director of Wellness documented at 3:34 PM was called to the Memory Care unit because resident #3 had agitation with other residents. Resident #3 was walking around the unit with his private sitter, pants had soiled feces on them. Attempted redirection but per sitter resident #3 has not been agreeable today. Finally, able to redirect resident #3 to his apartment to clean him up and change his clothes. He kept saying "leave me alone and stay away from me". He had the same behavior yesterday. Provided him with a , with vanilla ice cream at 4:14 PM. Will continue to monitor him every 30 minutes.	A 025		

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A 025	Continued From page 28 On at 8 PM by LPN F documented resident #3 was walking around the Memory Care with the private sitter, he observed having increased agitation and . On at 12:35 PM by LPN N documented spoke to resident #3's son for guidance and said he would not be at the facility for another hour or two. It was explained that resident #3 was being resistant and agitated. The son said that if staff ask resident #3 to get cleaned up for lunch that maybe he will at least allow staff to get him in clean clothes. On at 2:45 PM by LPN N documented resident #3, was agitated from trying to take the staff plates. When asked by the private sitter why she wasn't redirecting him, she answered "I won't let him hit me". Notified family and he said he would be at the facility within 30 minutes. The private sitter was nowhere to be found and resident #3 was sitting on the couch. On at 8:30 PM by LPN Q documented resident #3 was walking the halls and he kept walking behind the counter near the kitchen door. He had to be redirected 4 times but kept walking trying to open the cabinet door and slamming it. On at 8:49 PM by LPN L documented attempted to give resident #3 medications and he aggressively grabbed both arms of the nurse and quickly let go. Resident #3 refused to take his medication and continued walking around. Resident #3 also grabbed items off the med cart and throwing them. Will continue to monitor his behavior.	A 025		

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A 025	Continued From page 29 On at 6:25 PM by LPN K documented resident #3 was sitting in the dining room ready to eat dinner when he broke his fork and bangs the spoon on his . He did not injure himself, no cut on his . On at 7:30 PM by Director of Wellness documented resident #3 was ambulating the halls with private sitter, he started yelling as he went through the community. An attempt to redirect him with ice cream, unsuccessful. Resident #3 started chasing after staff and cornering staff. He took items off the medication cart and yelling. 911 was called. and law enforcement deputies came, then resident #3 sat down and calmly ate his ice cream. On at 1:24 PM by LPN M observed resident #3 had a behavior episode where he was trying to break his blinds and kick in the window. The practitioner ordered . On at 12 PM by LPN Q documented resident #3 refused his medications this morning, tried 3x but resident #3 did take his noon medication. Notified the family and physician. On at 6:35 AM by LPN F documented resident #3 non-compliant taking his 5 AM , after multiple attempts of encouragement. He was also signs of aggression and agitation, using fast loud voice and slamming doors and spit medication at the nurse. Notified the physician. On at 9 PM by LPN F documented during medication administration for resident #3, he spit out all his bedtime medications and swung his right arm striking the nurse on right cheek and attempted to spit on the nurse.	A 025		

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A 025	Continued From page 30 On at 5:41 PM by LPN K documented observed resident #3 showing aggression and agitation. On at 8:22 PM by LPN L documented while attempting medication administration to resident #3, he grabbed meds and threw them at the nurse. The private sitter reported he had aggressive behavior throughout the day because the private sitter was trying to give him a shower due to, he was covered in movement and being combative. On at 12:17 AM by LPN L documented resident #3 had aggressive behaviors and declined all night medications. Resident#3 eventually calmed down and went to sleep and continued to monitor. On at 8 PM by LPN F documented resident #3 was being , and non-compliant with his medications, he keeps spitting out medications onto the floor. On at 9:55 AM by LPN N documented that she left a voicemail message with resident #3's son of his behaviors & non-compliance with medications for several days. On at 8 PM by LPN F documented resident #3 observed ambulating in the hallway with his sitter at his side. He had an aggressive demeanor as resident #3 snatched his medication from the nurse's . He took his medication screaming and shouting through the halls. Will continue to monitor. On at 6:07 PM by LPN M documented that resident #3 was taking breakfast plates from	A 025		

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A 025	Continued From page 31	A 025		

other residents when the caregiver attempted to redirect, he hit her on her two times and picked up a coffee pot and aimed. His private sitter was eventually able to redirect him.

On at 8:45 PM by LPN F documented resident #3 observed awake in his apartment lying in his bed with an angry demeanor, clenched fists, tense posture and flushed in . He had increased volume when speaking. He was compliant with his medications after snatching it from the nurse's .

On at 6:04 PM by LPN M documented observed resident #3 pulling the dining room table and when he was redirected, resident #3 started to chase the nurse attempting to hit her. The sitter came and redirected him to his room.

On at 5:26 PM by LPN M documented resident #3 was observed walking in dining room during mealtime with no pants and no underwear. Attempted to redirect resident #3 and he put his on nurse and dug his nails in her arm. He was able to be redirected to his room to his private sitter by the caregiver in which he slapped her right arm. The family was notified.

On at 10:18 PM by LPN L documented resident #3 had aggressive behavior and declined his medications. Will continue to monitor.

On at 6:24 PM by LPN K documented observed resident #3 in his room with no pants and no underwear. Private sitter attempted to put pants on him, and he was trying to hit her but with lots of redirection he complied.

On at 12:37 PM by LPN J observed

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A 025	Continued From page 32 resident #3 in the dining room for breakfast. He is on for . On at 6:04 PM by LPN I documented observed resident #3 ambulating in the dining room attempting to push staff 3 times with multiple staff and had to be redirected. On at 7:49 PM by LPN F documented resident #3 declined his medications and observed an angry demeanor. On at 12:26 PM by LPN G documented resident #3 observed private sitter reported that resident #3 had . He was sitting on the edge of the bed and slipped onto the floor hitting his on the right side. A hematoma observed and resident #3 was not wearing non-slip socks. Informed the private sitter that resident #3 should be always wearing his non-skid socks. Resident #3 to be at baseline. 911 called and resident #3 was transported to the hospital. Notified family and physician. On at 5:26 PM by LPN G documented observed resident #3 walking around and eating. His hematoma appeared to shrink and observed minimal on the left side of . An observation on at 3:07 PM in resident #3's room. The private sitter and resident #3 were in the room. Resident #3 was trying to put his pants on and when the private sitter tried to assist him, he balled his fist attempting to hit the private sitter. The private sitter tried to redirect him but then resident #3 changed his mind and wanted to get into his bed under his blanket with his pants down by his . Furthermore, resident #3 has ripped down any items hanging in his room,	A 025		

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A 025	Continued From page 33 showing holes in the walls. The private sitter said that they keep minimal items in his room for safety purposes, because he will throw things around and at you. The private sitter said that she works with him on a 12-hour shift from 8am-8pm, and then a relief private sitter will work the next 12 hours from 8pm-8am. The private sitter said that resident #3 has reached a plateau on his medications and suggested that his medications be reviewed by the physician with the possibility of increasing the dosage or trying another medication to help his moods and behaviors. On at 9:50 AM, an interview with the Director of Wellness said that the physician has changed his medications for the behaviors and provided me with the change log for resident #3's medications. After further review of the medication change log for resident #3 revealed there were no medications changes. All the medications remained the same. On at 11:20 AM, an interview with the Administrator confirmed all the findings above. (Photographic Evidence Obtained) Class II	A 025		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168	A 079		

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A 079	Continued From page 34 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.	A 079		

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A 079	Continued From page 35 b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident	A 079		

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A 079	Continued From page 36 care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that	A 079		

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A 079	Continued From page 37 resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on facility documentation, family interviews and interviews, the facility failed to have enough working staff, there was only one caregiver (W) who worked alone with 26 total residents in Memory Care on . Four family members had to assist their loved ones for bed (#15, #16, #17, #18). Findings: A review of the staff work schedule for the week of - revealed Caregiver W and Caregiver X were scheduled to work on from 3PM-11PM in the Memory Care unit. The census on /26 was 26. Caregiver X left work and went home without the Memory Care Director's approval because she did not want to work in Memory Care. This left Caregiver W to work alone with the 26 residents in the memory care unit. On at 2:45 PM, an interview with Caregiver	A 079		

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W said that she worked alone with all the Memory Care residents, about 25 total on on the 2nd shift (3 PM-11PM). Caregiver W stated management did not thank her and did not talk to her about that night.

On at 3:34 PM, an interview with the Memory Care Director said that she was not aware that Caregiver W worked alone in the Memory Care unit on , until the next morning. She confirmed that Caregiver X did not want to work in Memory Care and left the facility. The Memory Care Director said that she did not reprimand Caregiver X because of the shortage of staff.

On at 9:34 AM, an interview with the Director of Wellness stated that she was not aware that Caregiver W worked alone on (2nd shift 3PM-11 PM).

On at 10:10 AM, a family telephone interview for resident #17 said that she observed Caregiver W working alone on at about 7:30 PM when she was visiting. She stated that she had surgery, so she was only there for a quick visit. The family member saw that Caregiver W was working very hard by herself by keeping the Memory Care residents entertained in the common living room where most of the residents congregate. Around 7:35 PM, Caregiver W tried to clean up and start taking some of the residents to their rooms for bed. The family member said that while Caregiver W was doing that, she stayed in the common living room to watch and keep an , on all the other residents , around. The family member said that she felt bad for Caregiver W that she volunteered to wash resident #17's and assisted with putting on pajamas for bed.

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A 079	Continued From page 39 On at 10:30 AM, a family telephone interview for resident #15 stated that she and husband were visiting her dad on to put a new bed mattress in his room around 7 PM. She confirmed that she saw that Caregiver W was working alone in Memory Care. The family member said that it was odd because it was Memory Care and there should be more staff working with at least 20 residents with memory , . The family member did assist with activities of daily living (ADLs) to her father (resident #15) by getting him ready for bed voluntarily because she felt bad for Caregiver W that was cleaning up and assisting other residents to bed alone. On at 2:27 PM, a family telephone interview for resident #18 confirmed that yes Caregiver W was working alone on around 6PM when she came to visit her mother (resident #18). The family member said she volunteered to assist her mother (resident #18) with activities of daily living (ADLs) for bed that evening because Caregiver W had a lot of other things to get done. The family member stated that Caregiver W started early getting some of the residents to bed and during this time, there were three other families visiting and assisting their loved one for bed. The family member stated that no one never came over to Memory Care to check on Caregiver W during the evening. On at 2:54 PM, a family telephone interview for resident #16 said that she was glad that the agency was looking into this matter because it bothered her seeing Caregiver W working alone with about 25 residents at approximately 6:30 PM on . The family member confirmed that she was visiting her	A 079		

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A 079	Continued From page 40 mother (resident #16) that evening. The family member added that some of the residents were sundowning and had some behaviors. There were few residents that were trying to get up and out of their wheelchairs to walk, thank goodness no one . The family member confirmed that she did assist with grooming to her mother (resident #16) before bed voluntarily because Caregiver W looked overwhelmed and the family member wanted to make sure that her mother (resident #16) got the proper care that night. The family member finally stated that she did not think the new Administrator was aware of what had gone on. On at 10:50 AM, an interview with the Administrator confirmed the findings. (Photographic Evidence Obtained) Class III	A 079		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored	A 055		

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	AL11969935	A. BUILDING: _____ B. WING _____	02/03/2026

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A 055	Continued From page 41 if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed.	A 055		

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A 055	Continued From page 42 (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep medication stored in a secure place, for 1 of 5 sampled resident's (#10). Findings:	A 055		

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A 055	Continued From page 43 Review of resident #10's health assessment form (1823) dated revealed, resident required assistance with medication self-administration. On at 9:41 AM, observed , , , , and 1% cream on the residents table in her room. During an interview on at 9:42 AM, resident #10 said she does not need assistance with the medications observed in her room. Resident said her other medications are kept on the medication cart. During an interview on at 12:27 PM, the findings were discussed with unlicensed caregiver A, who confirmed the findings. The caregiver said she did not know why those medications were kept in the resident's room. The caregiver added she knows that the medications are not supposed to be stored in resident #10's room. During an interview on at 12:34 PM, the Director of Wellness said the medications should not be in resident #10's room and it is preferred if the medications are stored on the medication cart. The facility's medication storage policy revised , indicated medications shall be properly stored and safeguarded to prevent access by unauthorized persons. The policy further indicated no medication shall be left in a resident's apartment unless the resident has a designated cabinet/compartment which is kept locked in the apartment of each resident who has been authorized in writing to self- administer by a physician or other authorized health care	A 055		

Agency for Health Care Administration

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A 055	Continued From page 44 provider. (photographic evidence obtained) Class III	A 055		