

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
NAME OF PROVIDER OR SUPPLIER THE GARDENS ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 10845 WEST GEM STREET CRYSTAL RIVER, FL 34428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint investigation (complaint number 2025017481 and 2026000025) was conducted at The Gardens Assisted Living & Memory Care on Deficiencies were identified at the time of the survey.	A 000		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (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. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ~ ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 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	A 165		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

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A 165	Continued From page 1 resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (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. (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. (6) . . . , neglect, or . . . must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, 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	A 165			

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A 165	Continued From page 2 by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (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. (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. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an Adverse Incident Report to the Agency for Healthcare Administration for 2 of 6 sampled residents (Resident #3 and #4) involved in a physical altercation resulting in a significant , , and emergency hospital transfer. Findings Include: A review of Resident #3's record revealed an admission date of . The Physician consult note dated read, HPI (History and Present Illness): , , male presents after getting into an altercation with another resident at his assisted living facility. Assessment and Plan: , male with stable subacute hematoma after assault at ALF." Physician Services Patient Visit Summary dated	A 165			

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A 165	Continued From page 3 read, "1. Hematoma- staff reports patient was sent to [name of hospital] Crystal River on after an altercation with his roommate. Patient was found to have a hematoma and transferred to [name of hospital] main. He was tx (treated) and returned to facility on ." Review of Resident #4's record revealed an admission date of . A progress note dated read, "resident was found on top of another resident [Resident #3] hitting the other resident 3x in the ." During an interview on at 12:57 PM, the Administrator stated, "We notified DCF [Department of Children and Families], but we didn't report the incident to AHCA [Agency for Healthcare Administration] for an adverse report. I did not think it was something we could have prevented." Review of the facility's Policy titled "Incident and Adverse Event Reporting" policy states, "In addition to completing an Incident Report, Adverse Event Day 1 and Day 15 Forms shall be completed and reported to the state licensing agency for any of the following: ; or , damage; Permanent ; or of bones or joints; Any condition that requires medical attention ... including any condition that requires the transfer of the resident to the hospital or emergency room; , neglect or ." Class III	A 165			