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
	AL11963865	A. BUILDING: _____ B. WING _____	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE SENIOR LIVING	4201 SPRINGTREE DRIVE SUNRISE, FL 33351

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A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by	A 056		

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A 056	Continued From page 1	A 056		

the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S.,

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A 056	Continued From page 2 before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure prescribed emergency end of life medications were available and properly administered for 1 of 1 sampled resident, Resident #1 who was experiencing distress. The findings include: Review of Resident #1's medical record indicated the resident is receiving hospice services for diagnosis of . The resident has additional diagnosis including , Hyperkalemia, Prostatic Hyperplasia ( ), and . The resident is alert to person only, follows commands but requires frequent reorientation and has intermittent agitation. the resident has history of and distress. Review of Resident #1 hospice note dated at 0002 the hospice provider call center receives call from facility that Resident #1 is having trouble breathing. Per caller Resident#1 does not have ( ), treatment or available. The Call Center alerts hospice provider on call nurse. The facility ALF staff calls to the call center confirming that the concentrator has been located on the balcony. The ALF staff places at 2L on the	A 056		

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A 056	Continued From page 3 resident. Further review of the hospice nurses note dated revealed the ALF called reporting Resident#1 was having ( ). Resident #1 is observed laying on his hospital bed, , rate is 30/min, labored breathing, gasping for air using accessory , sounds , ALF staff is unable to access Resident #1's comfort medication kit and . The note indicates that the ALF staff inform hospice nurse she does not have the key for the medication cart. The resident is placed on 4L via . A phone call is placed to the resident's health care provider, with no answer. Facility staff call 911 for transport to the hospital for evaluation and treatment. In an interview with the Director of Nursing (DON) on at 12 PM, she acknowledged an incident involving Resident #1 on , who was having , distress and the hospice nurse was contacted. The DON stated that the hospice nurse arrived to provide care and was unable to access prescribed comfort care medications. The DON stated that the emergency comfort kit medications could not be found by the facility staff on duty since the medication box had been left on top of the medication cart and not placed in the routine location inside the cart. The DON stated that facility staff have access to the medication cart located inside the nurses station. She stated that the resident's family had previously refused administration of any hospice comfort medications, only allowing to be placed on resident. The DON stated that device was missing from the resident's room until staff located the concentrator outside on the	A 056		

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A 056	Continued From page 4 balcony. The DON stated that Resident#1 had recently been on hospice 24-hour crisis care prior to this event. The DON stated that the decision to transfer Resident#1 due to , , distress was made by the facility. In an observation of the "nurses" medication cart located in the Nurses Station on at 12 PM, the RCD used a key to open the cart located inside the nurses station. The DON identified several boxes as hospice "comfort care medications". Class III	A 056		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (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: 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 to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes,	A 152		

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A 152	Continued From page 5 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (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 . This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe living environment free from hazards by ensuring that all structural, mechanical and electrical systems were maintained in good working order. The facility failure to maintain these systems placed residents at risk of substantial harm. The findings include: In an interview with the Administrator on at approximately 11:30 AM, she stated that an incident had occurred on involving Resident #2, when a freestanding metal closet/ cabinet had tipped over on top of the resident. The Administrator stated she had the cabinet removed from the room immediately after the incident. She stated the cabinet was not secured to the wall. The Administrator stated that she wasn't sure why the cabinet tipped. On at approximately 1:15 PM, a tour	A 152		

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A 152	Continued From page 6 was conducted in the hallway on the 3rd floor, outside /1306, 2 areas of chipping paint were observed on the hallway ceiling. On one of the areas a Wi-Fi electrical box was connected with a wire conduit running over the damaged area. See photo evidence. In an interview with the Maintenance Director at 1:15 PM, he stated that the chipping paint was a result of a roof leak with water damage. He stated that the facility was in process of securing bids for repair work but had no date of completion. In an interview and tour of the patio area with the Administrator on at 3:30 PM, a wooden fencing around the enclosed patio area directly off the Memory Care unit was observed rotten/ crumbling. The Administrator stated that the fence near the exit door had over, allowing the Resident #2 to exit thru the downed fencing. A padlock was observed locked on the gate. New wooden boards were observed securing the fencing. See photos. The Administrator stated the facility received corporate approval for patio upgrade and tree removal but are waiting on city code approval first, so new fencing will not be installed until upgrade is completed. In an observation on at approximately 4 PM, in the facility's memory care unit, a camera is observed located near exit door #4 where Resident #2 had eloped on . The Administrator stated that another memory care had tampered/ broken the original camera and unplugged the original camera. The Administrator stated that the camera was not working on day of incident and a new camera has been installed with plastic bubble cover attached to prevent residents disrupting the camera. Unprotected wiring from the camera to power unit was observed and exposed wiring to another camera	A 152		

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A 152	Continued From page 7 unit. See photo evidence. The Administrator stated she has tried to staple the cord to the wall, but the resident keeps messing and pulling at the power . She stated she is researching another option to prevent further camera disruption. Class III	A 152		
A 000	Initial Comments An unannounced Complaint investigation (#2026001128 and #2026001164) was conducted at Springtree Senior Living from - . The facility had deficiencies at the time of the survey.	A 000		
A 010	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 appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who	A 010		

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A 010	Continued From page 8 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 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.	A 010		

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A 010	Continued From page 9 (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 residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is	A 010		

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A 010	Continued From page 10 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 placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to	A 010		

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A 010	Continued From page 11 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 observation, interview and record review, the facility failed to ensure a Resident Health Assessment 1823 form was completed upon significant change and failed to re-assess for continued admission appropriateness based on health status change and care needs, for 1 of 1 sampled residents (Resident # 2) identified as an elopement risk and experiencing multiple . Cross- reference G 0025 and A 0032 for aditional information. The findings include: Resident #2 was admitted to the Assisted Living Facility (ALF) with medical diagnosis of on . Review of Resident #2's Resident Health Assessment form 1823 dated indicated medical history including , , , , , and . The form indicates Resident #2 is alert and oriented and ambulates with a walker. The resident requires assistance with ambulation, bathing, , toileting and transfers. Review of the facility nursing progress notes	A 010		

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A 010	Continued From page 12	A 010		

dated indicated the resident was found on the floor when failing to use the walker for ambulation.

Review of the facility nursing progress notes dated revealed Resident #2 was found on the floor and unable to describe what had occurred.

Review of facility investigation of an incident indicated on Resident #2 meets with another Spanish speaking resident at the ALF, and both go outside for a walk. Resident #2 ambulates with her walker unsupervised approximately 0.3 miles to a store located near the ALF. The investigation reveals the police call the ALF and return the resident at 8:15 PM. The resident informed the police that she was trying to leave the hospital, unable to describe where she lived, and that she was waiting for a family member.

In an interview conducted with the Director of Nursing (DON) on at approximately 11 AM, she stated that due to Resident #2 not following the facility's sign out policy when leaving the facility and increased , the facility changed her status to an elopement risk.

Review of Resident #2's facility records indicated no updated 1823 form with change of elopement status and precautions.

Review of the facility's nursing progress notes dated at 1:40 PM, revealed the facility nurse was called outside to the patio area, the nurse observed Resident #2 outside alone and had in a grassy area. The note indicated the resident stating she was looking for her son's car. The resident is unable to describe how she

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A 010	Continued From page 13 and complained of hitting her . Review of the facility's nursing progress notes dated identify Resident #2 as , ambulating throughout facility and attempted to exit through an emergency door at the rear of the facility. In an interview with the DON on at approximately 11:30 AM, she stated Resident #2 was found through the facility and found at the of the facility attempting to exit. The DON stated that Resident #2 was becoming more into other resident's rooms. The DON stated that the facility suggested moving the resident to the Memory Care unit in the facility which would provide a more secure environment. The DON stated that Resident #2 was moved into the memory care unit on . Review of the facility's investigation documenation indicated on at approximately 6:35 PM Resident #2 was identified by staff as missing. Staff searched the memory care unit and notified the lead staff member along with the Licensed Practical Nurse (LPN) on duty that Resident #2 was missing. The LPN was informed that the police had called the facility and requested to come pick up Resident #2. The note indicates at 7:20 PM the LPN drove to location and transported Resident #2 to the facility. The Administrator, based on the elopement and safety concerns implements 1:1 additional staff monitoring 24/7 for Resident #2. Review of the facility nursing progress notes dated at 2:23 PM revealed the facility received a call from Resident #2's family that the closet in the resident's room over on top of the	A 010		

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	AL11963865	A. BUILDING: _____ B. WING _____	02/06/2026

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A 010	Continued From page 14 resident. The 1:1 aide intervened, pushing the closet upright against the wall. Review of video clip provided by Resident #2's family for review revealed on the cabinet in Resident #2's room on the resident. (See video evidence). Review of written documentation of video camera timeline provided by Resident #2's family member on revealed the family received a call from the hospital at 8:33 PM, informing them that Resident #2 is being discharged to the ALF on . The family called the facility to alert them of the resident's return. Review of video clip provided by Resident#2's family for review revealed on at 8:58 PM, Resident #2 is returned to the ALF. The 1:1 private aide was not present when Resident #2 arrived at the ALF. Video provided revealed 2 transport personnel putting Resident #2 into bed. Video reviewed revealed no facility staff are observed to meet/assess the resident on readmission or to toilet the resident. (See video evidence). Review of the facility nursing progress notes at 9:28 PM, revealed the facility received a call from family, informing them that Resident #2 was observed falling, striking her and on the hospital bed. The facility called 911 to transfer Resident #2 to the hospital for evaluation. Review of video clip provided by Resident#2's family for review revealed Resident #2 standing at side of her bed, she ass observed to be unsteady on her , loses her balance, and backward hitting and on bedframe. There was no walker observed next to bed. (See video	A 010		

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A 010	Continued From page 15 evidence). Resident #2 is left alone with no 1:1 private aide for approximately 30 minutes. In an interview with the Administrator on at approximately 3:30 PM, she stated that the hospital did not inform the facility that Resident #2 was returning on and that the private aide was on her way to the facility to begin a scheduled shift at 10 PM. Class II	A 010		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification 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.	A 025		

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A 025	Continued From page 16 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the 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 the resident. This was evidenced by the failure to ensure the physical and , , well-being of 1 of 1 sampled residents, (Resident #2) who had with a known history of	A 025		

Agency for Health Care Administration

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A 025	Continued From page 17	A 025		

and several elopements from the facility and failure to ensure appropriate supervision for prevention.

The findings include:

Resident #2 was admitted to the Assisted Living Facility (ALF) with medical diagnosis of on . The resident's family installs video cameras in the resident's room.

Review of Resident #2's Resident Health Assessment form 1823 dated indicated medical history including , , , , and . The form indicates Resident #2 is alert and oriented and ambulates with a walker. The resident requires assistance with ambulation, bathing, , toileting and transfers.

Review of the facility nursing progress notes dated indicates the resident was found on the floor when failing to use the walker for ambulation. The resident is documented as having no apparent injury yet admits she hit her and refuses to go to the hospital for evaluation.

Review of the facility nursing progress notes dated Resident #2 is found on the floor and unable to describe what had occurred. The resident is assessed to have no injury.

Review of the Social Worker notes date indicated visit was a referral for difficulty adjusting to placement at the ALF. The note indicates the resident has increased sadness and emotional distress due to loss of independence and separation from her family. The note indicates the resident needs assistance,

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A 025	Continued From page 18 and no family member is available at home The resident expresses , misses her husband and has close relationships with family. The resident has mild memory , with fair judgement. The social worker assesses the resident to have , symptoms, exacerbated by the move to ALF and has , memory decline. The plan included continuing , , services, supportive services for grief, loss, and contacting the family to discuss plan of referral of , , . Review of the facility nursing progress notes dated indicates Resident #2 complaining of painful . New medication orders are received. Review of the facility nursing progress notes dated indicated that Resident #2 was observed to ambulate throughout the facility hallways. On at 8:15 PM the facility receives a call from police stating that Resident #2 was found away from the facility. The police indicate the resident informs them that she was trying to leave the hospital, unable to describe where she lived, and that she was waiting for a family member. Resident #2 is returned to the facility; she has no apparent injury. Review of facility investigation of an incident indicated on Resident #2 meets with another Spanish speaking resident at the ALF, and both go outside for a walk. Resident #2 ambulates with her walker unsupervised approximately 0.3 miles to a store located near the ALF. The investigation reveals the police call the ALF and return the resident at 8:15 PM.	A 025		

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A 025	Continued From page 19 In an interview conducted with the Director of Nursing (DON) on at approximately 11 AM she stated that due to Resident #2 not following the facility sign out policy when leaving the facility and increased , the facility changed her status to an elopement risk. The DON stated that Resident #2 would enjoy spending time outside. Review of Resident #2's facility records indicated no updated 1823 form with change of elopement status and precautions. Review of the facility nursing progress notes dated at 1:40 PM, the facility nurse is called outside to the patio area, the nurse observes Resident #2 is outside alone and has in a grassy area. The note indicates the resident stating she was looking for her son's car. The resident is unable to describe how she and complains of hitting her . 911 emergency is called and the resident is transferred to the hospital for evaluation. Review of Resident #2's hospital note dated indicated the resident is diagnosis of hematoma and . Review of the facility nursing progress notes dated indicated Resident #2 returns to the ALF. The resident missed a , on due to hospital admission. Further review of the facility nursing progress notes for Resident #2 indicated no nursing checks were conducted after readmission. No updated 1823 form was provided with precautions.	A 025		

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A 025	Continued From page 20 Review of the facility nursing progress notes dated identify Resident #2 as , ambulating throughout facility and attempting to exit thru an emergency door at the rear of the facility. In an interview with the DON on at approximately 11:30 AM she stated Resident #2 was found through the facility and found at the of the facility attempting to exit. The DON stated that Resident #2 was becoming more into other resident's rooms. The DON stated that the facility suggested moving the resident to the Memory Care unit in the facility which would provide a more secure environment. The DON stated that Resident #2 was moved into the memory care unit on . In an interview with Resident #2's family member on at approximately 11:00 AM stated that they had not been informed of the transfer until they observed on video camera clips from Resident#2's room, that her bed and TV were missing. The family stated that their phone service had been due to a nationwide phone outage. Review of the facility nursing progress notes dated 11 Am indicates a call was placed to the physician and family representative. Review of the facility investigative records indicated on , Resident #2 exits through a side patio door in Memory Care unit which leads to an enclosed patio area. The exit door #4 has 2 alarms, both did not sound, and were . The wooden fencing around the enclosed patio area was rotten and part of the fence had over, allowing Resident #2 to exit through downed fencing. Resident #2 ambulates 0.8 miles to a strip mall/plaza where police find the resident and call the facility. The facility	A 025		

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A 025	Continued From page 21 investigation determines that the video camera located near the exit door where resident exited, was broken and had been unplugged by another memory care resident. There was no video evidence to review per the Administrator. Per staff interviews conducted by the facility Resident #2 was last seen by memory care staff at 6 PM when she was placed in the activity room. In an interview with Resident #2's family member on at approximately 11:00 AM stated based on video from Resident #2's room camera she was last seen in her room on at 5:35 PM. Review of the facility adverse incident report filed with the Agency indicated on at approximately 6:35 PM Resident #2 was identified by staff as missing. Staff search the memory care unit and notified the lead staff member along with the Licensed Practical Nurse (LPN) on duty that Resident #2 was missing. The report indicates that the LPN drove around the community for minutes and then returned to the facility. Upon return his report he was informed that the police had called the facility and requested to come pick up Resident #2. The note indicates at 7:20 PM the LPN drove to location and transported Resident #2 to the facility. Review of the facility incident elopement drill form dated indicated Resident #2 was assessed by the LPN to have no injuries. The Administrator is notified by the LPN of the elopement and implements 1:1 staff monitoring 24/7 for Resident #2. In an interview with the Administrator on at approximately 3:45 PM she stated she has not been able to replicate or determine how/why the exit door alarms (2) did not activate on	A 025		

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A 025	Continued From page 22 when Resident #2 eloped. She stated that all of the exit doors in the Memory Care unit were immediately checked and reset by the LPN upon Resident #2's return to the facility. The Administrator stated that she called the family to inform them that she had placed Resident #2 on 1:1 PDA monitoring due to the elopement and for the resident's safety. The Administrator acknowledged that she informed Resident#2's family to either "come get her immediately" or the resident required extra 1:1 staff monitoring. The Administrator stated that due to the incident and the facility's inability to provide ongoing 1:1 additional staff monitoring for the resident, a 45-day notice of termination would be issued. The Administrator stated that she had issued the 45-day notice on /206 and mailed it certified to the address noted on Resident #2's demographic sheet indicating emergency contact/responsible person. Review of the facility "45- day Notice of Termination of Residency "dated indicated "written notice effective on , as your behaviors and failure with general policies of the community, have made the community unable to meet your needs and exceeds the level of care we can provide". Review of the Advanced Practice Registered Nurse (APRN) note dated indicated a , , evaluation for , , was completed on Resident #2 Review of the note indicated medication review and adjustment. The assessment completed indicated "other , , not due to substance or known physiological condition". The treatment plan included refill , 50 mg,1 tab in AM and 2 tabs at 9 PM.	A 025		

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A 025	Continued From page 23 Review of the facility nursing progress notes dated at 1:55 PM, Resident #2 in the main lobby while ambulating with the 1:1 aide. Resident #2 hits her and is transferred via 911 to the hospital. Resident #2 returns to the facility on . Review of the hospital record for Resident#2 dated indicated diagnosis including concussion, hematoma , left ankle , and blunt . The hospital note indicates Resident#2 is unable to describe what occurred. Review of the facility nursing progress notes dated PM indicates Resident #2 returns to ALF with no new orders. Further review of the facility nursing progress notes for Resident #2 indicated no nursing checks were conducted after readmission. Review of the facility nursing progress notes dated at 9:30 AM Resident #2 is observed ambulating outside with the 1:1 private aide. At 11:48 AM the nurse is called to the resident's room and finds the resident initially unresponsive then Resident#2 begins to mumble with her closed. The LPN calls 911 for transport to the hospital for evaluation. Review of the hospital record for Resident#2 dated reveals a witnessed episode , with the resident not falling out of the chair or with any strike. The note reveals Resident #2 is about how she arrived at the hospital. She explains that her caregiver dropped to floor and that is when she started having problems. Medical personnel use a translation app to communicate with resident.	A 025		

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A 025	Continued From page 24 Review of the facility nursing progress notes dated Resident #2 is readmitted to ALF. Review of the updated 1823 form dated reveals diagnosis including , , , , myalgia, hematoma, repeated , history of , and . The form indicates the resident ambulates with a walker, she is alert but . The resident requires precautions and assistance with all activities of daily living along with medication management. Resident #2 is assessed as an elopement risk. Review of the health care provider note dated reveals Resident #2 had a witnessed , episode, she has protein calorie , , , , hematoma,and , . The note indicates Resident #2 is exit seeking with elopement with memory care placement, now requiring private duty monitoring 24/7. Resident #2 is unable to transfer without assistance, needs assistance for ambulation, shower/ grooming needs. She is identified as high risk, and requires precautions. Discussion with family about history of , , and , . Plan to consult with psychologist and continue on , , and , medications. Review of the facility nursing progress notes 12:30 PM the nurse is called to Resident#2's room and finds the resident unresponsive but reacts to a sternal rub. Resident #2 is transferred 911 to the hospital for evaluation. Resident #2 returns to the ALF on	A 025		

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A 025	Continued From page 25 Review of the facility nursing progress notes 2:23 PM the facility receives a call from Resident #2's family that the closet in her room has on top of the resident. The nurse finds Resident #2 sitting in her wheelchair. The 1:1 private aide informs the nurse that Resident#2 was reaching for clothes and the closet leaned on her. The aide intervenes pushing the closet upright against the wall. Family requests 911 transfer to evaluate and properly assess for injury. Review of video clip provided by Resident #2's family for review reveals time stamp at at 2:20 PM Resident #2 is observed taking clothes out of the freestanding metal closet in her room. The private 1:1 aide is observed sitting across the room, with a computer open and cell phone in . The metal cabinet is observed to over on top of Resident #2 and the aide gets up from the chair and runs over to resident and pushes cabinet against wall. See video evidence. Review of written documentation of video camera timeline provided by Resident #2's family member on reveals Resident #2 is placed in a wheelchair and wheeled out of her room by the 1:1 private aide. At 2:56 PM personnel arrive. At 3:07 PM facility maintenance staff are observed to remove the unsecured metal cabinet from Resident #2's room. Per family hospital assessed the resident and , revealed T-11 , . The timeline indicates the family received a call from the hospital at 8:33 PM, informed that Resident #2 is being discharged to ALF. The family then calls the facility to alert them of the return. The family requests that Resident #2's medications are administered. The nurse on duty indicates	A 025		

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A 025	Continued From page 26 that she is covering the other side of facility but will contact the memory care unit staff of the resident's return. Review of video clip provided by Resident #2's family for review reveals on 8:58 PM Resident #2 is returned to the ALF. The 1:1 private aide is not present when Resident #2 arrives at the ALF. Video provided reveals 2 transport personnel putting Resident #2 into bed. Video reviewed revealed no facility staff are observed to meet/assess the resident on readmission or to toilet the resident. See video evidence. Review of the facility nursing progress notes 9:28 PM facility receives call from the family, informing that Resident #2 is observed falling, striking her and on the hospital bed. The facility calls 911 to transfer resident to the hospital for evaluation. Review of video clip provided by Resident #2's family for review reveals Resident #2 standing at side of her bed, she is observed to be unsteady on her , loses her balance, and backward hitting and on bedframe. There is no walker was observed next to bed. See video evidence. Resident is left alone with no 1:1 private aide for approximately 30 minutes. In an interview with the Administrator on at approximately 3:30 PM she stated that the hospital did not inform the facility that Resident #2 was returning on and that the private aide was on her way to the facility to begin scheduled shift at 10 PM. Review of the written documentation of video clip activity timeline inside Resident #2's room on	A 025		

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(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 025	Continued From page 27 /206 provided by the family revealed: 9:34 PM Medication Staff enters room with 2 other aides. Resident is on the floor. Medication staff Resident #2 a cup of medications, prescribed and , 9:35 PM An Aide states "Nick not here. No nurse in memory care". 9:36 PM All staff leave room, leaving Resident #2 sitting on floor alone 9:40 PM another aide comes into the room and bends to speak with resident 9:58 PM arrives and transports Resident #2 to the hospital. No one including speaks Spanish, so family member speaks via camera to . Family member gives the resident's medical history and informs that Resident #2 had just received and , . . . A Hospital physician calls family to inquire why Resident#2 was being transported to the hospital, the family send video of resident falling,hitting her . Resident was admitted to the hospital and as of continues as an inpatient receiving , , . . . Class II	A 025		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or 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 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963865	A. BUILDING: _____ B. WING _____	02/06/2026

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A 032	Continued From page 28 a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement	A 032		

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A 032	Continued From page 29 response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure their elopement policy was implemented to monitor residents that are assessed at risk for elopement. This was evidenced by the failure to have required photo identification of the resident accessible to all staff and failure to update the resident assessment on file for staff awareness to provide required monitoring for safety and whereabouts to 1 of 1 sampled residents, (Residents #2) who had prior history of _, exit seeking and elopement. Cross reference A 0025 for additional information. The findings include: Resident #2 was admitted to the Assisted Living Facility (ALF) with medical diagnosis of on . Review of Resident #2's Resident Health Assessment form 1823 dated indicated medical history including , , , , , , and . The form indicates Resident #2 is alert and oriented and ambulates with a walker. The	A 032		

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A 032	Continued From page 30 resident requires assistance with ambulation, bathing, ␣, toileting and transfers. Review of the facility nursing progress notes dated indicated that Resident #2 was observed frequently ambulating throughout the facility hallways. On at 8:15 PM the facility receives a call from police stating that Resident #2 was found away from the facility. The police indicate the resident informs them that she was trying to leave the hospital, unable to describe where she lived, and that she was waiting for a family member. Resident #2 is returned to the facility, she has no apparent injury. Review of facility investigation of an incident indicated on Resident #2 meets with another Spanish speaking resident at the ALF, and both go outside for a walk. Resident #2 ambulates with her walker unsupervised approximately 0.3 miles to a store located near the ALF. The investigation reveals the police call the ALF and return the resident at 8:15 PM. In an interview conducted with the Director of Nursing (DON) on at approximately 11 AM she stated that due to Resident #2 noncompliance with following the facility "sign out" policy when leaving the facility, increased , and ␣, the facility changed her status to an elopement risk. The DON stated that Resident #2 preferred to spend time outside. Review of Resident #2's facility records indicated no updated 1823 form with the change of elopement status. Review of the facility nursing progress notes dated at 1:40 PM, the facility nurse is	A 032		

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A 032	Continued From page 31 called outside to the patio area, the nurse observes Resident #2 is outside alone and has in a grassy area. The note indicates the resident stating she was looking for her son's car. The resident is unable to describe how she and complains of hitting her . 911 emergency is called and the resident is transferred to the hospital for evaluation. Review of the facility nursing progress notes dated identify Resident #2 as , ambulating throughout facility and attempted to exit through an emergency door at the rear of the facility. In an interview with the DON on at approximately 11:30 AM she stated Resident #2 was found through the facility and found at the of the facility attempting to exit. The DON stated that Resident #2 was becoming more into other residents' rooms. The DON stated that the facility suggested moving the resident to the Memory Care unit in the facility which would provide a more secure environment. The DON stated that Resident #2 was moved into the memory care unit on . Review of the facility investigative records indicated on , Resident #2 exits through a side patio door in Memory Care unit which leads to an enclosed patio area. The exit door has 2 alarms, both did not sound, and were . The wooden fencing around the enclosed patio area was rotten and part of the fence had over, allowing Resident #2 to exit through downed fencing. Resident #2 ambulates 0.8 miles to a strip mall/plaza where police find the resident and call the facility. The Administrator is notified by the charge nurse of the elopement and implements 1:1 staff monitoring 24/7 for Resident #2.	A 032		

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A 032	Continued From page 32 Review of the updated 1823 form dated reveals diagnosis including and repeat . The form indicates the resident requires precautions and assistance with all activities of daily living including assistance with medication management. Resident #2 is assessed as an elopement risk. In an interview with the Front Desk Concierge on at 10:20 AM she stated residents who are identified as elopement risks have a picture in the logbook kept at the front desk. She opens a logbook titled elopement risk and was unable to show a photo of Resident #2. She stated that staff would alert her if a resident was missing. She stated she was unfamiliar with Resident#2. In an interview with the DON on at 11 AM she stated that Resident #2 was reassessed after the 1st "elopement" event and facility decided to list her as an elopement risk. She stated that Resident#2 didn't follow the facility sign out policy and was increasingly . She stated that the resident was very active, ambulated throughout the facility and became more and began to exit seek. She stated when the resident would leave the building, she would be difficult to redirect inside. The DON acknowledged that she had not placed a photo of the Resident #2 in the front desk elopement log book since the resident was identified as an elopement risk on . Class II	A 032		