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
	AL11968333	A. BUILDING: _____ B. WING _____	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE JUPITER	1031 COMMUNITY DRIVE JUPITER, FL 33458

(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 (#2025018087 & #2026001944) and Generator Monitoring survey was conducted on , , at Addington Place Jupiter. The facility had deficiencies identified related to Complaint #2026001944 at the time of the visit.	A 000		
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. 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 025		

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A 025	Continued From page 1 (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, record review and interviews, it was revealed that the facility failed to provide adequate supervision of 1 of 3 sampled residents (Resident #1) who resided in the secured unit. The findings included: Resident #1 was admitted to the Assisted Living Facility (ALF) Memory Care Unit (MCU), a locked secured unit on . The resident's health assessment (AHCA Form 1823) dated notes that the resident has diagnoses of	A 025		

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A 025	Continued From page 2 and recurrent ( ) and is independent with all activities of daily living (ADLs). The assessment has marked "yes" for the inquiry as to whether or not the resident is at risk for elopement. The MCU consists of two exit doors at the end of the hallway where the resident's room is located, one with a screeching alarm when opened if the switch is in the "on" position and another that requires a code or an employee's electronic card to open with an alarm sounding and automatically opening if the handle is pressed more than 15 seconds (egress door). There are two double doors that require a code or an employee's electronic card to open, or open automatically with an alarm sound if the handles are pressed on for more than 15 seconds (egress doors), that allow access to a screened patio with a screen door that remains unlocked. There are also two additional doors that require staff opening with a code or card that leads to the interior of the building, with an additional code secured door to the hallway. On at 7:03 AM, it is noted on an incident report that Resident #1 was found outside in the MCU secured courtyard. It is unknown how long the resident was outside, or when the resident exited the interior of the building as there are no cameras in the common areas and no scheduled checks of the approximately 18 residents in the MCU. All of the residents in this unit require staff to their needs due to and are expected to consistently be monitored for their safety. Twelve (12) residents are listed by the facility as "at risk for elopement" and need additional monitoring for safety as they are capable of exiting the unit and placing themselves in danger. During interview with the	A 025		

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A 025	Continued From page 3 Health and Wellness Director (HWD) on at 11:15 AM, she stated that the staff were expected to check on the residents two to three times an eight (8) hour shift, but there was no scheduled times to check on the residents' well-being or whereabouts. There are three (3) caregivers including the "Med Tech" assigned to these residents during the evening shift and two (2) for the night shift. The facility's investigation of the incident that occurred on shows that Resident #1 was last seen by the MCU Director at 4:30 PM on walking to the dining room for dinner. There was no required check of residents in the MCU for mealtimes to ensure they had eaten or arrived at the dining room. This resident was supposed to have medication disbursed one hour before or one hour after 8:00 PM, again at 9:00 PM, and again at 9:30 PM. It was documented that she received this medication all three times by Staff C on . However, inquiries during the investigation by the facility revealed Staff C "mistakenly" documented the resident was given this medication when she was allegedly told by Staff B that the resident was out with family at that time. Staff B, who was assigned to care for the resident during the 3:00 PM to 11:00 PM shift, stated during interview on at 2:30 PM that she thought the resident was out with family as she "heard from others", and confirmed she did not check the 24-hour report where this would be noted. The resident's family has a camera with recording in the resident's room and reported that Staff A entered the resident's room around 11:40 PM to check on the resident, saw that the resident was not in the room, and left the room. It is not known if the resident was inside the secured unit building or outside in the courtyard at that time, as there was no search conducted by	A 025		

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A 025	Continued From page 4 either staff member assigned to the resident (Staff A or B) due to them assuming that the resident was out with family. The facility's investigation determined that three (3) staff members (Staff A, B and C) did not follow protocol for supervising residents in the MCU during two different shifts. Review of the website (timeanddate.com) shows the temperatures in Jupiter, Florida from 6:00 PM on through 6:00 AM on ranged from 54 to 70 degrees. It is unknown how long the Resident was outside in the courtyard when found at 7:03 AM, as the following systems in place to ensure supervision of residents in the MCU were not followed. 1. There is no checking with documentation of residents seen during meals in the secured unit. 2. Medication pass completed in the evening or at nighttime was documented erroneously for this resident on . 3. Staff assigned to care for this resident from 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts did not check the sign out sheet or 24-hour report to see if the resident was signed out by family on . 4. The Health and Wellness Director and/or Memory Care Unit Director do not consistently note residents out of the facility as on a "leave of absence/LOA" on the electronic MOR (medication observation record) so that Med Tech's will know definitively if they should be looking for a resident to pass medication or not. This was evidenced by review of Resident #1's MOR on that did not have "LOA" noted anywhere when the resident had not returned to the facility since . 5. There is no policy and procedure in place to ensure the residents are secure inside the building after dark or when temperatures outside could be harmful to residents with	A 025		

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A 025	Continued From page 5	A 025		

, in the secured unit. There are no scheduled checks of residents in the MCU, with documentation to ensure staff are actually observing the residents during the "checks".
6. There is no policy and procedure in place to check the operation and functioning of the automatic door locks as well as the functionality of the alarms in the secured unit.
7. There is no assurance that the "huddle" for discussing changes in residents that is expected to be conducted during shift changes will be done or any documentation required of this communication.

During tour of the secured unit with the Administrator and Health and Wellness Director on at 2:00 PM, it was revealed that the second exit door at the end of the hallway where Resident #1 resides was opening inconsistently without activating an alarm or requiring residents to press down on the latch for a length of time (15 seconds) before releasing. Furthermore, the egress door that is required to open after 15 seconds, and activates an alarm, has an alarm that automatically stops after a certain period of time without staff having to intervene. The Administrator stated during interview at 3:00 PM on that the company responsible for the repair of this door was present and working on the functionality.

There was an "extra" screeching alarm that was present high on the left side of the first door to exit into the courtyard, that could be disengaged by family, residents or staff members who could reach it. There was no policy and procedure in place to ensure this alarm was set or checked daily for its operation and engagement.
One of two doors used to enter the dining room area was locked and could not be opened from

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A 025	Continued From page 6	A 025		

the outside, but the other door was able to be opened from the outside without an alarm activating. It is unknown if Resident #1 had tried to reenter the interior of the building through one of these doors, and if they had been activated as there was no electronic recording of doors being opened or alarms being activated. There was also no video surveillance of common areas available for additional supervision of residents.

Staff C stated during a telephonic interview at 2:25 PM on that she made a mistake when noting on the MOR that Resident #1 received her medication around 8:00 PM as she was told by Staff B that the resident was out with the family. During a telephonic interview on at 2:30 PM with Staff B, she stated the door alarms were not operating properly at times but were the night this resident walked outside because she checked the "screeching" alarm. She stated that the staff did not conduct a "huddle" to communicate with each other during shift change about any residents who might not be at the facility. Staff B was assigned to care for Resident #1 during the 3:00 PM to 11:00 PM shift.

The incident that occurred on and involving Resident #1 was preventable. The failure to follow protocol from three (3) facility staff during two shifts placed the resident in danger of serious harm. The absence of scheduled observations of residents in the MCU with , allowed direct care staff to not be held accountable for minimum standards of care when , the supervision needs of residents. These findings were discussed with the Administrator and Health and Wellness Director during interview at 3:45 on . The facility provided no additional information for review at

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A 025	Continued From page 7 this time. 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 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.	A 032		

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A 032	Continued From page 8 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 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, record review and an interview, the facility failed to ensure 12 of 12 sampled residents at risk for elopement (Residents #1-#12) had identification on their person checked at a minimum once daily for application as part of their policy and procedure to prevent elopement. The findings included:	A 032		

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A 032	Continued From page 9 On at 12:00 PM, a tour of the secured unit was conducted. Residents #2 and #3 were present at the facility with no identification on them. Resident #1 was not at the facility at this time. During interview with the Health and Wellness Director at 1:00 PM on , documentation showing daily checks conducted of residents at risk for elopement was requested. A list of 12 residents updated on showed the residents currently at risk (Residents #1-#12). There was no documentation available for review to show any checks of these residents' identification completed daily. Class III	A 032		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The	A 052		

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A 052	Continued From page 10 resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations.	A 052		

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A 052	Continued From page 11 (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , ˳ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and	A 052		

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A 052	Continued From page 12	A 052		

make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.

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A 052	Continued From page 13 (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on record review and interviews, it was revealed that "Med Techs" (unlicensed staff) trained to assist residents with self-administration of medication were not following statutory guidelines when providing this assistance, for 1 of 3 sampled residents (Resident #1). Cross reference A 0025 for addition information. The findings included: The Health and Wellness Director stated during interview at 11:00 AM on that Staff C had erroneously intialed on the MOR that Resident #1 received all of the 8:00 PM, 9:00 PM and 9:30 PM prescribed medications from her on when the resident did not receive any medication. Review of the MOR for Resident #1 was conducted on . Staff C's "correction" of the 8:00 PM, 9:00 PM and 9:30 PM medication documentation dated on the MOR revealed the following: a. Staff C noted the resident was "OOF" (out of the facility) for , and . The resident had not left the facility. b. Staff C noted the medication was "CE" (charted in error) for and Relief. There was no documented details of what error occurred. c. Staff C left intialed as given at 8:00 PM on when it had not been provided. Staff C stated during a telephonic interview at	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968333	A. BUILDING: _____ B. WING _____	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 052	Continued From page 14 2:25 PM on that she made a mistake when noting on the MOR that Resident #1 received her medication around 8:00 PM on , as she was told by Staff B that the resident was out with family, and meant to document this. However, the resident was not out with family, and was present at the facility. Staff C did not check the 24 hour report or with any supervisor to confirm that the resident was not present in the facility. Additionally, there was no "huddle" conducted during the beginning of her shift at 3:00 PM, to discuss any changes in residents' status or those out of the facility. B. Resident #1 had not been at the facility since 8:00 AM on . The , MOR showed that two different staff members (other than Staff C), Staff D and B, had initialed that they gave Resident #1 at 9:30 PM on and respectively. The resident did not receive these medications. The procedure for unlicensed staff to follow when providing assistance with self-administration of medication requires them to bring the labeled medication to the resident and confirming that the medication is intended for that resident the label, as well as keeping a record of this assistance. These findings were acknowledged by the Administrator and Health and Wellness Director during interview on at 3:45 PM. The facility provided no additional information for review at this time. Class II	A 052		
A 054	59A-36.008(5) FAC Medication - Records	A 054		

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A 054	Continued From page 15 (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was revealed that the MORs (medication observation record) was not accurate and up-to-date for 1 of 3 sampled residents (Resident #1). The findings included:	A 054		

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A 054	Continued From page 16 A. The Health and Wellness Director stated during interview at 11:00 AM on that Staff C had erroneously initialed on the MOR that Resident #1 received all of the 8:00 PM, 9:00 PM and 9:30 PM prescribed medications from her on when the resident did not receive any medication. Staff C was allowed to reenter her initials and change the previous errors in documentation on the , MOR without any notation of the previous misinformation. Review of the , MOR for Resident #1 was conducted on . Staff C's "correction" of the 8:00 PM, 9:00 PM and 9:30 PM medication documentation dated on the MOR revealed the following: a. Staff C noted the resident was "OOF" (out of the facility) for , and . The resident had not left the facility. b. Staff C noted the medication was "CE" (charted in error) for and Relief. There was no documented details of what error occurred. c. Staff C left initialed as given at 8:00 PM on when it had not been provided. Staff C stated during a telephonic interview at 2:25 PM on that she made a mistake when noting on the MOR that Resident #1 received her medication around 8:00 PM on , as she was told by Staff B that the resident was out with family, and meant to document this. B. Resident #1 had not been at the facility since 8:00 AM on . During interview with the Health and Wellness Director on at 2:40	A 054		

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A 054	Continued From page 17 PM, she acknowledged that she had not entered a "LOA/leave of absence" into the electronic system which would prevent Med Techs from documenting erroneously that they had provided a resident medication when they had not when the resident was not present. The MOR showed that two different staff members (other than Staff C), Staff D and B, had initialed that they gave Resident #1 at 9:30 PM on and respectively. The resident had not been at the facility since 8:00 AM on , so did not receive these medications. These findings were acknowledged by the Administrator and Health and Wellness Director during interview on at 3:45 PM. The facility provided no additional information for review at this time. Class III	A 054		