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
	AL11965048	A. BUILDING: _____ B. WING _____	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OVIEDO	1725 PINE BARK OVIEDO, FL 32765

(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 the facility reviews and interviews the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 days of the incident for 3 of 7 sampled residents. (#12, #14, #15)	ZZ821		

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ZZ821	Continued From page 4 Findings: 1. Review of resident #14's record revealed a facility admission on . A 1823 health assessment indicated a risk. Review of a facility note dated at 2:52 PM, the responsible party notified the facility that the resident is discharged from the hospital today or tomorrow and will go to a rehab for approximately 20 days. Review of a facility note dated at 1:26 PM, at approximately 8:49 PM, caregiver reports finding resident on the bathroom floor with pants down. Resident complained of , following the and family requested to be sent to hospital. was contacted and transfer proceeded. On at 2:29 PM, the responsible party stated the resident reached up for the grab bar and , adding this was the first at the facility. On at 1:09 PM, the HWD stated they did not submit an adverse report for the and was under the impression that they did not need to do if there was no . 2. Review of resident #12's record revealed a facility admission date of . Review of an 1823 (health assessment form,) dated , revealed a medical history of , , and the need for and precautions. The 1823 indicated the resident was alert and oriented, had intermittent , was forgetful, fatigued easily, and had decreased endurance. The 1823 form indicated the resident needed supervision	ZZ821		

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ZZ821	Continued From page 5 with ambulation and transferring and assistance with toileting. Review of a facility health assessment, dated , revealed it determined the resident's frequency of was monthly and risk factors included gait problems, , , and a history of . Review of a facility risk assessment tool, dated , revealed a score of 7, which the tool categorized as home health , , evaluation and prevention treatment. Review of a facility note dated at 6:23 PM, revealed when the resident stood up from her bed to greet a visiting family member, she on her right side on the floor. The note indicated the family member said the resident hit her . The note indicated the resident sustained a small on her right forehead. The note indicated emergency services were called and the resident was transported to a hospital. The note indicated the resident returned to the facility at 10:20 PM. Review of a hospital document, dated , revealed the resident was seen for a with a and . During an interview on at 11:30 AM, the Wellness Director said she did not submit the preliminary and full reports when the resident on and went to a hospital because the resident did sustain a . 3. Review of resident #15's record revealed a facility admission date of . An 1823 form, dated , revealed a diagnosis of . The 1823 form indicated that the resident was a	ZZ821		

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ZZ821	Continued From page 6 risk, had poor endurance, was unable to walk long distances, had memory loss and forgetfulness, had , and needed reminders. The 1823 form indicated the resident needed a walker for short distances and was independent with ambulation and transferring. Review of a facility note dated , indicated that at approximately 9 AM, the nurse entered the resident's room and heard the resident calling for help. The note indicated the nurse located the resident sitting on the floor between the bed and window. The note indicated there was a moderate amount of from a injury and that the resident was on a . The note indicated that emergency services were called and the resident was transported to a hospital. Review of a facility note dated at 2:37 PM, revealed that the Wellness Director documented that a hospital case manager reported the resident had 20 staples placed on her and a scan of her was negative for . During an interview on at 4:04 PM, the Wellness Director said she did not submit the preliminary and full reports when the resident and went to a hospital on then said she should have. On at 4:15 PM during a conference call, the Administrator confirmed the findings. Unclassified	ZZ821		
A 000	Initial Comments A re-licensure survey, complaint investigation	A 000		

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A	Continued From page 7 #2026000183, and generator monitoring was conducted at Madison at Oviedo on - . The facility had deficiencies 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 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	A 010		

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A 010	Continued From page 8 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. (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.	A 010		

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A 010	Continued From page 9 (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 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	A 010		

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A 010	Continued From page 10 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 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.	A 010		

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A 010	Continued From page 11 This Statute or Rule is not met as evidenced by: Based on resident record reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 1 of 7 sampled residents (#14) as required in an assisted living facility (ALF). Findings: Review of resident #14's record revealed a facility admission on . A 9 24/25 1823 health assessment indicated able to self-administer medications. Review of a facility note dated at 9:31 AM, medications are administered by clinical staff as ordered. The resident continue to experience , , , related to medication administration process. Review of a facility note dated at 8:02 AM, resident continues to experience / , , , related to medications or the process of taking medications. On at 2:29 PM, the responsible party of resident #14 stated the facility administers her medications to her. Adding, when she moved in, she was able to self-administer but we changed it to the facility. On at 2:40 PM, Unlicensed Caregiver A stated she administers medications to the resident. On at 4:05 PM, the HWD stated when resident #14 first moved in she was able to	A 010		

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A 010	Continued From page 12 self-administer but then sometimes afterwards her family wanted the facility to take over. Further stating, we did not get an updated 1823. The facility failed to obtain an updated 1823 when resident #14 was no longer able to self-administer her own medications. On at 4:15 PM during a conference call, the Administrator confirmed the findings. (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 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.	A 025		

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A 025	Continued From page 13 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, 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, interviews, and record reviews, 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	A 025		

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A 025	Continued From page 14 measures to minimize the potential for with injuries or for 3 of 7 sampled residents (#1, #12, #15.) Findings: 1. Review of resident #1's record, who resides in a memory care unit revealed a facility admission on . A 1823 health assessment indicated a medical history of , alert, disoriented, and identified as a risk. The residents' activities of daily living revealed she needed assistance with ambulation, , self-care, toileting, and transferring. Review of a risk assessment revealed a score of 9. Further review revealed a risk factor for , ability to perform ADLs indicates requires help with bathing, getting dressed, using the toilet, eating, or moving from bed to chair; risk factor of , indicating problems with memory, forgetting things more than most people; risk factor for gain and balance indicates feels like are unsteady on your . Review of a risk assessment revealed a score of 9. Further review revealed a risk factor for , ability to perform ADLs indicates requires help with bathing, getting dressed, using the toilet, eating, or moving from bed to chair; risk factor of , indicating problems with memory, forgetting things more than most people; risk factor for gain and balance indicates feels like are unsteady on your . An incident report dated indicated. At approximately 1345 hours (1:45 PM) a caregiver reported that the resident was observed on the floor in her apartment bathroom with active	A 025		

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A 025	Continued From page 15 present to the area. The nurse on duty entered the resident's apartment bathroom at approximately 1348 hours (1:48 PM) to assess the resident and found her prone on the bathroom floor with slightly turned to the side, with visible still present. At approximately 1350 hours (1:50 PM) emergency medical services ( ) were activated via 911 by the nurse on duty. arrived at approximately 1355 hours (1:55 PM) and transported the resident to the hospital for further evaluation and treatment. Review of the medical examiner's report dated indicated resident #1's date of on cause of blunt and with who suffered a ground-level . Review of the hospital report dated with a discharge date on indicated female brought in as a alert on from her Skilled Nursing Facility (SNF). The patient has past medical history (PMH) of . Patient was brought in via after sustaining a ground level , unwitnessed, while trying to stand in the bathroom at her SNF. Patient struck her and sustained a large forehead with visible calvarium. Patient was found to have , greater , non-displaced C1 right lateral arch , C2 type III odontoid with , displacement, C2 body , and /5 endplate . Extubating was attempted on , episode of resulting in an , event, requiring emergent re- . Patient's clinical status declined rapidly after this event. Family	A 025		

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A 025	Continued From page 16 proceeded with comfort care and patient expired on . Review of a facility note dated at 11:31 AM, caregiver reported to the Health and Wellness Director resident had another episode at lunch table where she wasn't responding like usual and had a blank stare. The nurse on duty notified primary care physician (PCP). Review of a facility note dated at 9:47 PM, the time of occurrence/observation by staff of the resident on the floor in her restroom was approximately 1340-1345 hrs. (1:40 - 1:45 PM) on . Review of a facility note dated at 8:28 PM, caregiver reported that the resident experienced a with active . LPN M immediately responded to assess the resident and found her prone on the bathroom floor with slightly turned to the side, with visible . The resident exhibited labored , and acute agitation attempting to self-transfer from the floor. Emergency Medical Services ( ) arrived promptly and transported the resident to the hospital for further medical evaluation and treatment. Review of a facility note dated at 5:07 PM, Licensed Practical Nurse LPN M reported she spoke with a family member, and the resident was admitted to the hospital and awaiting ( ) results. Review of the facility's Policy stated to provide proper intervention and follow through in the event of a resident . In the event of a witnessed or unwitnessed internal investigation will be completed to determine cause of ,	A 025		

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A 025	Continued From page 17 appropriate interventions for safety, and full body assessment to determine if further medical intervention is required. Any injury requiring more than soap, water, and a Aid will be sent to the ER for evaluation and treatment. On at 10:23 AM, the Activities Director stated she did not provide care to resident #1. Adding she was aware resident #1 needed assistance with her activities of daily living (ADL's). She further stated, when resident #1 needed to use the bathroom, she would call the staff to assist her. On at 10:35 AM, Caregiver D stated she was not working the day resident #1 in the bathroom. Further stating, resident #1 does require assistance with toileting. She stated she would sit resident #1 on the toilet and the resident would ask that you step out giving her privacy while she used the bathroom. Caregiver D stated she would step out around the corner not leaving the room and was able to hear the resident when she called to say she was finished. On at 12:45 PM, Caregiver C stated she worked the overnight shift. During her shift resident #1 was always in bed and didn't need to get up to go to the bathroom. Adding, she would change her in bed. On at 9:44 AM, Caregiver H stated she did provide care to resident #1 and when toileting she would stay by the door and did not leave the room. Further stating, resident #1 would always say she needed 5 minutes when using the bathroom. Adding, resident #1 was total care in her opinion when using the bathroom and could not be left alone.	A 025		

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A 025	Continued From page 18 On at 9:57 AM, Caregiver I stated resident #1 knew when she had to go to the bathroom. Adding, she would take her, sitting her on the toilet. Further stating, resident #1 had a small table and chair outside of the bathroom where she would sit and wait for the resident to finish. The Caregiver stated resident #1 would say give her 5 minutes which meant she needed her privacy. Once she was done, Caregiver I stated she would go in and assist the resident by putting her . . in the wheelchair. On at 10:13 AM, Caregiver G stated resident #1 was someone else's responsibility that day as they were assigned halls. Adding, resident #1 asked to go to the restroom stating she needed 5 minutes. Caregiver G stated she told the assigned caregiver to resident #1 that she put her on the toilet. Caregiver G stated when she returned from lunch, she saw the resident was not at the table where she usually sits. Adding, she ran to the room and found resident #1 on the floor and ran to go get help. She stated the resident was breathing and scared. Adding, resident #1 would never try to get up from the toilet by herself and always needed help ad it looked as though she forward off the toilet. Caregiver G stated she asked Caregiver L why she didn't check on resident #1. Adding, Caregiver L told her that she didn't hear her say she put resident #1 on the toilet. Caregiver G added, she has assisted resident #1 many times before and knew the resident needed assistance when using the restroom. She stated resident #1 was not her normal self at breakfast and was kind of spacey and told the nurse on duty. On at 10:33 AM, a family member of the resident stated resident #1 was confined to a wheelchair and required assistance toileting.	A 025		

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A 025	Continued From page 19 Further stating, that was normal for the resident to ask for 5 minutes when needing to use the restroom, being discreet and asking for privacy. On at 11:26 AM, LPN M stated the caregiver reported to her that resident #1 had a blank stare and when she assessed her the resident was to normal. Further stating, there was no evidence of . LPN M stated to her recollection she was up at the nurses' station when the caregiver told her that resident #1 had . Adding, she ran to the room and saw resident #1 , grabbing a towel and calling 911. During the call, 911 walked her through what to do. Adding, the resident kept trying to get up and she told her to stay down as help was coming. Further stating, the resident had labored breathing. On at 12:09 PM, Caregiver P stated she never really was assigned the hall where resident #1 resided but she knew resident #1 needed help when using the bathroom. Adding, when she did assist resident#1, she would take her, sit her on the toilet, and wait in the room. Further stating, resident #1 would always say to give her 5 minutes. The caregiver stated she would say Alexa put 5 minutes on and after the 5 minutes she would go in and assist the resident with standing up. Adding, resident #1 needed assistance with everything while using the bathroom. On at 1:17 PM, the Health and Wellness Director (HWD) stated resident #1 required assistance, adding the nurse on duty came down to assist with the . Further stating, when she arrived downstairs at the memory care unit Caregiver G, the staff who had provided assistance to the resident told her that the	A 025		

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A 025	Continued From page 20 resident was on the floor. The HWD stated "for any resident who you have to provide assistance, transfer mobility, you stay with them." Adding, the caregiver stated that she took resident #1 to the bathroom around 1:10 - 1:15 PM, helped her on the toilet, gave her 5 minutes, and stepped out of the bathroom to give her privacy. The HWD added she did see a week prior that the resident had a blank stare and they were to monitor and inform the doctor. Further stating, she advised Caregiver G that she was not properly supervising the resident. The HWD stated Caregiver G told her around lunch that resident #1 was having another episode of blank stare and did not tell anyone prior to. On at 1:38 PM, the Administrator stated he was made aware afterwards, indicating the , that resident #1 required assistance with toileting. Adding, for memory care we treat everyone as a risk as the general practice. Further stating, for all residents required some supervision. The Administrator stated it was determined that Caregiver G was not in close proximity to hear the resident call for help. The Administrator was unable to confirm the location of Caregiver G at the time of the incident when asked if the caregiver went to lunch. Caregiver G clocked out at 1;16 PM and did not clock in when asked to review the time sheet which was not provided. The Administrator was asked what preventative measures were put in place due to the incident involving resident #1. He stated he put a corrective action plan in place the day of the incident, completing the day 1 adverse, reported that privacy was honored, giving the resident minutes on a regular basis. Adding, Caregiver G was immediately suspended and in which she voluntarily terminated her position when she was told the facility needed to do an investigation.	A 025		

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A 025	Continued From page 21 Further stating, the facility created assistance with toileting, best practice in service training. They created an audit tool check list identifying risk status, bathroom safety check, caregiver knowledge (ask), documentation check, and results requiring to be dated and signed by the nurse. Adding, if the staff is unable to pass or answer correctly, they will be retrained. The facility also conducted in-service training's on , , , , , , , , and covering prevention with focus in bathroom. Review of the audit tool revealed it was implemented on and continued , /20/26, , 12 days after the of resident #1. On at 4:15 PM during a conference call, the Administrator confirmed the findings. 2. Review of resident #12's record revealed a facility admission date of . Review of an 1823 (health assessment form,) dated , revealed a medical history of , , and the need for and precautions. The 1823 indicated the resident was alert and oriented, had intermittent , was forgetful, fatigued easily, and had decreased endurance. The 1823 form indicated the resident needed supervision with ambulation and transferring and assistance with toileting. Review of a facility health assessment, dated , revealed it determined the resident's frequency of was monthly and risk factors included gait problems, , and a history of	A 025		

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A 025	Continued From page 22 Review of a facility risk assessment tool, dated , revealed a score of 7, which the tool categorized as , , , , evaluation and prevention treatment. Review of the resident's record found no documentation to indicate , , , , was considered. Review of a hospice case sheet revealed the resident was admitted to services on . Review of a hospice pre-admit evaluation, dated , revealed the resident had multiple aneurysms in her that were slowly , causing , , , and . The evaluation indicated the resident had 7 since , . Review of a facility note dated , revealed the resident said she had an unwitnessed on the previous night. Review of a facility note dated at 6:23 PM, revealed when the resident stood up from her bed to greet a visiting family member, she on her right side on the floor. The note indicated the family member said the resident hit her . The note indicated the resident sustained a small on her right forehead. The note indicated emergency services were called and the resident was transported to a hospital. The note indicated the resident returned to the facility at 10:20 PM. Review of a hospital document, dated , revealed the resident was seen for a with a and .	A 025		

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A 025	Continued From page 23 Review of a facility note dated at 7:15 PM, revealed the resident was found on the floor by a caregiver during morning rounds. The note indicated the resident was sitting on the floor in the bathroom doorway. The note indicated the resident said she lost her balance and while trying to go to the bathroom. The note indicated the resident said she hurt her , right , and that her whole body hurt. Review of a facility note dated at 6:15 AM, revealed the resident had an unwitnessed . The note indicated a caregiver was doing last rounds and when she tried to open the resident's door, the resident's body was blocking it. The note indicated the caregiver could not fully open the door and did not want to harm the resident by pushing harder. The note indicated emergency services were called and the resident was transported to a hospital. Review of a facility note dated at 9:06 PM, revealed the resident's family member reported the resident's left was during the . Review of a facility note dated , revealed the resident was transferred from the hospital to a rehabilitation facility. Review of a facility note dated , revealed the resident's family member reported the resident , while on hospice care in the rehabilitation facility. During an interview on at 11:47 AM, caregiver N said it was she who first tried to enter the resident's room on at approximately 6 AM. Caregiver N said it was a chair, and not the resident's body, blocking the door from the inside.	A 025		

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A 025	Continued From page 24 Caregiver N said she could not fit her through the opening. Caregiver N said she did not see resident #12 through the opening but could hear and speak with her. Caregiver N said the resident asked for help and said she was on the floor. Caregiver N said emergency personnel entered the room. Caregiver N said she last saw the resident at approximately 4:30 AM when the resident was in her bed with her , closed. Caregiver N said the resident was independently mobile. Review of the policy dated , revealed any identified risk and interventions to help decrease the risk for and injury will be determined, put in place, and documented on the resident's care plan. The policy went on to indicate that care plans will be updated for each and referrals will be made to , . Review of the resident's service plan revealed it was first initiated on . The plan revealed interventions were added on only and not after each . 3. Review of resident #15's record revealed a facility admission date of . An 1823 form, dated , revealed a diagnosis of . The 1823 form indicated that the resident was a risk, had poor endurance, was unable to walk long distances, had memory loss and forgetfulness, had , and needed reminders. The 1823 form indicated the resident needed a walker for short distances and was independent with ambulation and transferring. Review of a facility health assessment, dated , revealed it determined the resident's frequency of was none and the risk factor was assistive device.	A 025		

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A 025	Continued From page 25 Review of a facility risk assessment tool, dated , revealed a score of 5, which the tool categorized as , , , evaluation and prevention treatment. Review of a facility note, dated , indicated that at approximately 5:34 PM, the resident was found on the floor in front of her bed following an unwitnessed . Review of a risk assessment, dated , revealed a score of 6. Review of a facility note dated , indicated that at around 9:20 AM, the resident was found by a physical , on the resident's bathroom floor. The note indicated the nurse observed the resident sitting on the floor and leaning towards the shower. The note indicated the resident sustained a 2-centimeter on her right . The note indicated that the resident said she felt , . Review of a facility note dated , indicated that at approximately 9 AM, the nurse entered the resident's room and heard the resident calling for help. The note indicated the nurse located the resident sitting on the floor between the bed and window. The note indicated there was a moderate amount of from a injury and that the resident was on a . The note indicated that emergency services were called and the resident was transported to a hospital. Review of a facility note dated at 2:37 PM, revealed that the Wellness Director documented that a hospital case manager reported the resident had 20 staples placed to her and a scan of her was negative for	A 025		

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A 025	Continued From page 26 During an interview on at 9:40 AM, caregiver H said resident #15 preferred to stay in her room and needed encouragement to come out. The caregiver said the resident did not ask for assistance, she toileted herself, and ambulated independently with a walker. The caregiver said she found the resident's gait to be steady. During an interview on at 9:52 AM, caregiver I said that sometimes the resident declined assistance with in the morning, stating she could dress herself. The caregiver said resident #15 needed reminders to perform tasks or come to meals. The caregiver said the resident ambulated independently with a walker and went from her room to the dining room and only. The caregiver said she did not see the resident exhibit unsafe behaviors. During an interview on at 10:08 AM, caregiver D said resident #15 was mostly independent with the activities of daily living. The caregiver said that some days the resident did not get out of bed on her own so staff assisted her with . The caregiver said the resident ambulated independently with a walker. The caregiver said she found the resident's gait to be steady. The caregiver said the resident wore shoes when she walked but that she walked on the heels. The caregiver said that sometimes the resident forgot to use her walker. During an interview on at 10:21 AM, licensed practical nurse (LPN) J said the resident needed reminders to attend meals. The LPN said resident #15 used a walker when ambulating.	A 025		

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A 025	Continued From page 27 During an interview on at 10:30 AM, the Wellness Director said the resident did not receive , , , . During an interview on at 12:06 PM, caregiver P said the resident usually stayed in her room with the door closed and required reminders to attend meals. The caregiver said the resident ambulated independently with a walker and found the resident's gait to be steady. The caregiver said the resident toileted herself. Review of the resident's service plan revealed it was first initiated on . The plan revealed it was not updated for each thereafter. During an interview on at 1:30 PM, the Wellness Director said she was responsible for updating the service plan post then said she missed updating resident #12's and #15's plan. Class II	A 025		
A 052 SS=D	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.	A 052		

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A 052	Continued From page 28 (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 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	A 052		

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A 052	Continued From page 29 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. (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	A 052		

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A 052	Continued From page 30 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 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	A 052		

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A 052	Continued From page 31 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. (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 interview and record review, the facility failed to ensure a resident's refusal to take a medication was reported to a health care provider and documented in the resident's record for 2 of 7 sampled residents (#10, #14.) Findings: 1. During an interview on at 10:24 AM, resident #10 said that when she asked for her sleeping pill late at night unlicensed caregiver F refused to give it and told the resident that she did not need it. Review of resident #10's and MORs (Medication Observation Records) revealed unlicensed caregiver F documented "2" (drug refused) on , , , , , , , , , and . There was no documentation on either the MORs or the residents' record to indicate the refusals were reported to a health care provider. Unlicensed caregiver F was unavailable for an interview at the time of the survey. Review of the facility's policies on medication refusals, updated on , revealed the	A 052		

Agency for Health Care Administration

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A 052	Continued From page 32 Wellness Director, nurse, or designee should contact the health care provider to report the refusals once it was refused for 3 consecutive days and the notification should be documented in the resident record. During an interview on at 3:19 PM, the Wellness Director said unlicensed caregiver F told her a few times when the resident refused the . During an interview on at 3:42 PM, the Wellness Director said she did not report the refusals to a health care provider, nor could she locate documentation of anyone else reporting it. 2. Review of resident #14's record revealed a facility admission on . A 1823 health assessment indicated able to self-administer medications. Review of resident #14's and MORs revealed Unlicensed Caregiver A documented "2" (drug refused) on , , , , , , , , , , , and . There was no documentation on either the MORs or the residents' record to indicate the refusals were reported to a health care provider. Review of a facility note dated at 3:22 PM, responsible party visited with resident #14 and states he explained to her that if she continues refusing medication she may end up in the hospital. On at 2:29 PM, the responsible party of resident #14 stated the facility brings her the medications but she refuses.	A 052		

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A 052	Continued From page 33 On at 2:40 PM, Unlicensed Caregiver A stated she administers medications to the resident. Adding, when she refuses, she tells the nurse and they tell the family. On at 4:05 PM, the HWD stated they were reporting to the family that the resident was refusing her medications. Further stating, they were informing the doctor but failed to document each time in the resident record. On at 4:15 PM during a conference call, the Administrator confirmed the findings. (photographic evidence obtained) Class III	A 052		
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 if: 1. The facility administers the medication; 2. The resident requests central storage. The	A 055		

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A 055	Continued From page 34 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. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate,	A 055		

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A 055	Continued From page 35 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 interview and record review, the facility failed to document disposal of medications in the record of 1 of 7 sampled residents and failed to ensure the same resident was given their medications to store in their room as ordered by a health care provider (#10.) Findings:	A 055		

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A 055	Continued From page 36 During an interview on at 10:24 AM, resident #10 said that sometime within the last three weeks the Wellness Director removed her spray and , , from her room. Review of a facility note dated at 9:42 AM, revealed the Wellness Director documented that medications were found in the resident's room. During an interview on at 1 PM, the Wellness Director said she threw away the spray and , , she removed from the resident's room on because she did not know how old they were. The Wellness Director said she did not document her disposal of them. Review of the facility's medication destruction policies, updated , revealed when a medication was disposed of a medication disposal form would be completed then placed in the resident's record. Review of a health care provider's order, dated , revealed the provider ordered that the resident be allowed to self-administer the spray and , , , and store them in her room. During an interview on at 12:50 PM, the Wellness Director said the spray and , , were stored in the medication cart. On at 4:15 PM during a conference call, the Administrator confirmed the findings. Class III	A 055		