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
	AL11969590	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU MADELEINE	205 HARDOON LANE MELBOURNE, FL 32940

(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 A re-licensure survey and generator monitoring was conducted at Chateau Madeleine LLC. Assisted Living Facility & Memory Care on . The provider had deficiencies at the time of the survey visit.	A 000		
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. 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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 record review and interview the facility failed to provide care and services appropriate to meet the needs by failing to ensure employees verify and follow physician orders for 1 of 3 residents reviewed (#13). Findings: A review of resident #13's record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included and mesothelioma. He was independent with ambulation, eating, grooming.	A 025		

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A 025	Continued From page 2 He required supervision with and assistance with all other activities of daily living. A Review of the Medication Observation Record (MOR) found an order for 5 mg 1 tablet by daily. Hold for (B/P) less than 110. Start date . Further review of the MOR found on 5mg was signed as given at 8 AM. The area for is blank, indicating resident #13's was not taken. On 5mg was signed as given at 8 AM. The area for is blank, indicating resident #13's was not taken. On and the 5mg was held due to low . Continued review of the MOR found a second order for 10mg 1 tablet by daily. It was ordered on and discontinued on . This order did not have parameters. On and 10 mg was signed as given at 8 AM This is the same time as 5mg was given indicating resident #13 received 15 mg of on and 3 times the current dose ordered on . A review of the discharge orders from rehab for resident #13 found only the order for 5mg daily. Ordered on while in rehab.	A 025		

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A 025	Continued From page 3 Review of the facility notes found: On at 11:20 AM, resident #13 was sent out via fire rescue due to low , and low-grade . On Friday Licensed Practical Nurse (LPN) (F) documented at 3:11 PM, resident #13 returned to the facility. was documented as . There was no documentation of resident #13's Primary Care Provider (PCP) being notified or medication reconciliation/review with the PCP. On at 4:18 PM, the Administrator responded to an email from resident #13 son in law who was concerned about resident #13's , medications. The email was documented in the facility notes - I clarified that all medications were administered strictly in accordance with physician orders and pharmacy instructions. At no time were medications administered outside of those parameters. On at 4:45 PM the Director of Nursing (DON) documented an email in the facility notes that was sent to resident #13's PCP: Resident 13 returned from rehab on . He returned able to transfer and assist with ADLs. Yesterday, it took 4 staff to transfer him. He was sent to the Emergency Room due to being lowered to the floor and complaining of severe , . The next paragraph read - also his orders from rehab for , medications are , 5mg daily. Hold for , , less than 110. Also, an order for , without parameters. The DON then documents, asking the PCP if he would like to set parameters for , . There was no documentation of the PCP being advised of the 2 , orders.	A 025		

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A 025	Continued From page 4 On at 3:10 PM, an interview with the DON was conducted. She stated she did not know if resident #13's physician was notified when he returned from rehab. She said his doctor is hard to get. She also stated she was not in the facility at that time, and the nurse would have done the admission. The DON was provided a copy of resident #13's MOR. She confirmed there were 2 , orders and that both medications (5mg and 10mg) were given without verifying , was within parameters. She also confirmed there was no documentation of the PCP being notified about the unusual double , orders. She confirmed the order for , 10mg was an order from before rehab. The , 5mg was the order that resident #13 returned from rehab with. She confirmed she did not review resident #13's admission paperwork which included his medication orders. She again stated the nurse should have done that and she was not in the facility when the resident returned. On at 3:20 PM, an interview with LPN (F) was conducted. She confirmed she did not call resident #13's PCP when he returned to the facility. She stated she had orders from the doctor at the rehab. LPN (F) was provided with a copy of the , MOR to review, and confirmed there were 2 orders for the , , and both were signed as given. (Photo Evidence Obtained) Class II	A 025		

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A 040	Continued From page 5	A 040		
A 040 SS=D	429.55(2) F.S. Resident Education- (V (2) VTE CONSUMER INFORMATION.- (a) The Legislature finds that many , (PEs) are preventable and that information about the prevalence of the could save lives. (b) The term ", " means a condition in which part of the clot breaks off and travels to the , possibly causing . (c) The term " " means , which is a clot located in a deep , usually in the or arm. The term can be used to refer to , , , or both. (d) Assisted living facilities must provide a consumer information pamphlet to residents upon admission. The pamphlet must contain information about , including risk factors and how residents can recognize the signs and symptoms of . This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to provide upon admission, the facility's pamphlet regarding education about the clot consumer information provided to the resident and/or legal representatives for 2 of 2 sampled residents (#8, #15) as required effective . Findings: 1. A review of resident #8's record revealed date original admission on and a re-admission date of verified by the admission-discharge log reviewed.	A 040		

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A 040	Continued From page 6 2. A review of resident #15's record revealed date of admission on . There was no documented evidence that facility could provide that both residents and/or legal representatives received the clot consumer pamphlet at admission. On at 3:04 PM, an interview with the Administrator confirmed the findings and provided a / clot form he created today and said that he will provide to the residents during admission moving forward. (Photographic Evidence Obtained) Class III	A 040		