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
	AL11968608	A. BUILDING: _____ B. WING _____	R 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 revisit survey was conducted at Seasons Gardens Senior Residences from to . Deficiencies were identified at the time of survey.	{A 000}		
{A 036} SS=E	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to implement a hygiene program after the provision of personal services	{A 036}		

AHCA Form 3020-0001

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

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{A 036}	Continued From page 1 for two out of 33 residents (Resident #32 and Resident #33). Findings include: Observations on from 8:27 AM to 8:32 AM revealed that Staff CC (Home Health Aide) completed multiple tasks without washing : 8:27 AM: Staff CC brushed Resident #32 hair . 8:29 AM: Staff CC grabbed orange juice container and placed the container in the kitchen without washing . 8:30 AM: Staff CC went to Resident #32. 8:31AM: Staff CC grabbed Resident #33 cup water to place in front of Resident #33. Then grabbed orange juice container and poured water and orange juice into Resident #33's cup. 8:32 AM: Staff CC returned the water and orange juice container in the kitchen. Then grabbed coffee dispenser and poured coffee for Resident #33. A review of Staff CC's employee file revealed Staff CC received control, universal precautions and facility sanitation procedures training on . A review of Staff CC's employee file revealed Staff CC received control training on . Uncorrected Class III	{A 036}		

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A 054 SS=D	59A-36.008(5) FAC Medication - Records (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 allergies 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 restraints, as defined in Section 429.41, F.S., 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 interview, the facility failed to follow prescription orders for one out of 31 sampled residents (Resident #28).	A 054		

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A 054	Continued From page 3 Findings: A review of the , Medication Observation Record (MOR) for Resident #28 revealed that the resident was prescribed , (,) 5mg , 1 tablet by 3 times a day, one tablet at 8 AM, one tablet at 2 PM and one at 7 PM for , and , . A review of the , MOR for Resident #28 revealed that he received the , 1 tablet by 3 times a day from , to , . A review of the MOR for Resident #28 revealed that Resident #28 was ordered , 5mg 1 tablet by 3 times a day then it was changed to , 5mg, 3 tablets by daily (the three pills to be taken at once). A review of the MOR from to 8, 2025 revealed that Resident #28 received , one tablet 3 times a day. A review of the MOR revealed that Resident #28 did not receive the , from to . On -202026 at 1:30PM in an interview with the Director of Resident Care she stated that Resident #28 was hospitalized from , 2025. A review of the MOR revealed that on to he received 1 five milligram tablet of , 3 times a day. Further review revealed that from October 23 to 30, 2025, Resident #28 received 3 tablets of (5mg per tablet) one time a day. Additional	A 054		

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A 054	Continued From page 4 review revealed that on , Resident #28 received , 3 tablets at once and one 5mg tablet at 8 AM and one 5 mg at 2 PM. A review of the MOR revealed that the 7 PM order was not given on . The 7 PM order was discontinued. The MOR revealed that on . Resident #28 received a total of 25 mg of , . On , , Resident #28 received an extra 10 mg of , , than the ordered 15 mg per day. A review of the MOR revealed that both orders were carried out . Both orders overlapped, the one for 3 tablets of 5 mg each at one time in the day and the one for one five mg tablet 3 separate times during the day. As a result, documentation showed that on , , , Resident #28 received 25 mg total of the , when he should have only received 15 mg. In an interview on at 1:30PM, the Director of Resident Services, stated that the , was given at 8AM as the one time a day order. The Director of Resident Care stated that the medication was not given on the at 7 AM and 2 PM as per the 3 times a day order. The Resident Care Director stated that there was an internal system in the Electronic MOR that showed that on , Resident #28 only received the , at 8AM. Class III	A 054		
{A 058} SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.-	{A 058}		

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{A 058}	Continued From page 5 (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2),	{A 058}		

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{A 058}	Continued From page 6 F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to correct deficient practices related to medication. The facility is required to obtain a registered nurse or pharmacist consultant to develop and implement a plan of correction until these services are deemed no longer necessary by the Agency for Health Care Administration. Findings: A review of the facility's survey history revealed that the facility was cited for Medication Storage and Disposal and Medication Labeling and Orders on . A review of the , Medication	{A 058}		

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{A 058}	Continued From page 7 Observation Record (MOR) for Resident #28 revealed that the resident was prescribed , (,) 5mg , 1 tablet by 3 times a day, one tablet at 8 AM, one tablet at 2 PM and one at 7 PM for , and , . A review of the , MOR for Resident #28 revealed that he received the , 1 tablet by 3 times a day from , to , . A review of the MOR for Resident #28 revealed that Resident #28 was ordered , 5mg 1 tablet by 3 times a day then it was changed to , 5mg, 3 tablets by daily (the three pills to be taken at once). A review of the MOR from to 8 revealed that Resident #28 received , one tablet 3 times a day. A review of the MOR revealed that Resident #28 did not receive the , from to . On -202026 at 1:30PM in an interview with the Director of Resident Care she stated that Resident #28 was hospitalized from , 2025. A review of the MOR revealed that on to , he received 1 five milligram tablet of , 3 times a day. Further review revealed that from to -30, 2025, Resident #28 received 3 tablets of , (5mg per tablet))one time a day. Additional review revealed that on , , Resident #28 received , 3 tablets at once and one 5mg tablet at 8 AM and	{A 058}		

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{A 058}	Continued From page 8 one 5 mg at 2 PM. A review of the MOR revealed that the 7 PM order was not given on . The 7 PM order was discontinued. The MOR revealed that on . Resident #28 received a total of 25 mg of . On , Resident #28 received an extra 10 mg of , than the ordered 15 mg per day. A review of the MOR revealed that both orders were carried out. Both orders overlapped, the one for 3 tablets of 5 mg each at one time in the day and the one for one five mg tablet 3 separate times during the day. As a result, documentation showed that on , Resident #28 received 25 mg total of the when he should have only received 15 mg. In an interview on at 1:30PM, the Director of Resident Services, stated that the was given at 8:00 AM as the one time a day order. The Director of Resident Care stated that the medication was not given on the at 7 AM and 2 PM as per the 3 times a day order. The Resident Care Director stated that there was an internal system in the Electronic MOR that showed that on , Resident #28 only received the at 8:0 AM. Class III	{A 058}		