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
	AL11964870	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHPARK SENIOR LIVING	9461 HEALTHPARK CIRCLE FORT MYERS, FL 33908

(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 complaint investigation for #2026004511 was conducted at Healthpark Senior Living on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	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 record review, and interviews, the facility failed to notify the resident's Power of Attorney (POA) for changes in condition including an injury of unknown origin to the left and left , and the Nurse Practitioner's (NP) new order for , for 1 (Resident #1) of 3 residents reviewed for notification to the POA. The findings included: On at 1:03 p.m., during a telephone interview, the POA said he came to the facility on and found Resident #1 in a wheelchair,	A 025		

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A 025	Continued From page 2 unable to walk, and was complaining of , . He said no one at the facility notified him. He said he had the resident transported to the hospital. He said the resident was diagnosed with a left and left , . On at 10:45 a.m., during an interview, the Director of Nursing (DON) said the caregiver notified her about Resident #1's left injury on around midnight. The DON told the caregiver to put Resident #1 to bed. The DON said she came to the facility on and saw the injury. She said she notified the NP, but she could not reach Resident #1's POA. The DON said she had the POA's email, but she did not send an email. The DON said she observed Resident #1 from through . The DON said the resident was acting normal. On at 10:48 a.m., during the interview, the DON said on the caregiver notified her that Resident #1's POA was visiting Resident #1 in the cottage. The POA was upset and complained because he was not notified of the left injury. On at 12:12 p.m., during a telephone interview, the NP said she examined Resident #1 on . She said Resident #1 was in bed during the examination. She said she checked the left and the , She said the resident was , and did not show signs of , . She said she did not ask the resident to walk or stand. She said she did not order an , or to have the resident sent to the ER. She said she ordered the , three times a day because of the left injury. She said she tried to notify the POA but was not successful.	A 025		

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A 025	Continued From page 3 Record review revealed a late entry progress note by the DON dated at 5:34 p.m. for at 12:00 a.m., documented Resident #1 had a ˌ to left side of , left and left inner canthus [corner of ˌ were upper and lower lids meet]. The DON notified the provider but was unable to leave a message for the POA. Record review revealed a late entry progress note by the DON dated at 9:26 a.m. revealed on at 8:00 a.m, the DON was unable to get to the VM (voicemail) with POA. Record review of the Medication Observation Record (MOR) revealed a new order dated for , 500 mgs (milligrams) take one tablet by three times a day for 10 days. The MAR revealed the resident was given the medication on at 1:00 p.m. and 5:00 p.m. On , , and the MAR revealed the resident was given the medication at 9:00 a.m., 1:00 p.m., and 5:00 p.m. On , the facility documented Resident #1 received the medication at 9:00 a.m. The MAR revealed Resident #1 was out of the facility from through . Class III .	A 025		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to	A 165		

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A 165	Continued From page 4 assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15	A 165		

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A 165	Continued From page 5	A 165		

days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate

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A 165	Continued From page 6 regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to submit the preliminary adverse incident report within one (1) day and the full report within 15 days for 1 resident (Resident #1) of 3 residents reviewed for facility incidents. The findings included: Resident #1's progress note dated at 9:24 a.m. revealed Resident #1 was transported to the medical center for further evaluation after difficulty ambulating at the facility. The progress note included an update by the DON revealing Resident #1 sustained a left , and a left of unknown origin. On at 8:45 a.m., the Director of Nursing (DON) said she does not have access to report adverse incidents through the agency's online portal. She said the Executive Director is the only one with access. On at 3:03 p.m., the Executive Director (ED) said he did not know Resident #1 had a left , and left . He said he did not report the preliminary or the 15-day adverse incident report to the agency's online portal, but it should have been reported. On at 5:19 p.m., the DON said she has been working at the facility for 5 months. She said she does not have a log in to report to the State. She said she told the ED about Resident #1's and that she thought the incident	A 165		

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A 165	Continued From page 7 should be reported through the agency's portal. Class III .	A 165		