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
	AL11966084	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUSVILLE TOWERS	405 INDIAN RIVER AVENUE TITUSVILLE, FL 32796

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A 000	Initial Comments Complaint investigation #2026004471 and generator monitoring survey were conducted at Titusville Towers Assisted Living Facility with Extended Congregate Care (ECC) from to . The complaint was substantiated and Class I deficiency was identified for A0030 (Resident Care-Rights & Facility Procedures). A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to initiate , , ( ) for a , resident #1 who was a full code. On at approximately 5:45 AM, Unlicensed Caregiver A found the resident in her bathroom hunched over the sink. The resident was unresponsive and appeared blue in color. Caregiver A did not seek help from other staff and failed to initiate . The facility did not adhere to their policy that documented staff to perform if the resident did not have an existing ( ). The Class I noncompliance began on . The facility's Administrator was notified by telephone of the Class I noncompliance on at 12:30 PM. The census at the start of the survey was 94.	A 000		

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	A 025		
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) 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.	A 025		

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A 025	Continued From page 2 (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 facility's documentation and interview, the facility failed to maintain written documentation as required for 3 of 4 sampled residents (#1, #3, #4) involved in significant incidents that occurred at the facility. Findings: 1. Review of the facility's incident report dated at 5:45 AM, documented that Unlicensed Caregiver A went to resident #1's apartment to complete a Medication Pass that was due at 6 AM. The Unlicensed Caregiver A knocked on the door and entered resident #1's apartment, calling out to resident #1. She went to the resident's bedroom and did not see her in her bed, she then opened the bathroom door and saw resident #1 hunched over and wedged in between the	A 025		

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A 025	Continued From page 3	A 025		

bathroom sink and a small dresser. The resident was blue in skin color and not responding.

Unlicensed Caregiver A immediately called 911. She said she did not initiate as she was told by the 911 dispatcher not to touch the body and not to touch anything in the apartment. At 5:47 AM, police arrived at the facility, and shortly after at 5:50 AM, the emergency medical services arrived and used their defibrillator and the Automated External Defibrillator ( ) machine for the next 10 minutes. Resident #1 was pronounced at the facility. Unlicensed Caregiver A did not call for assistance from the other staff (Caregiver F) that were at the facility with her.

A review of resident #1's record revealed she was admitted to the facility on . The last 1823 Health Assessment form dated listed medical history of , achalasia, carotid and pains. She ambulated with a wheelchair and needed assistance with self-administration of medications. The health assessment form 1823 noted resident #1 was independent with all her activities of daily living (ADLs) and required no additional assistance. The resident was full code.

This was the only facility documentation about this incident on . There was no facility notes regarding this incident on in the file.

2. Review of the facility's incident report dated at 7:39 AM, during breakfast time, , resident #3- and resident

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A	Continued From page 4	A 025		

#4 got into a verbal altercation while coming down on the elevator. Resident #3 subsequently called law enforcement as she said she was afraid of resident #4. No charges were filed against either of the residents involved and they were told to stay away from each other. There were no injuries, just verbal words to each other.

A review of the brief police incident report on at 7:28 AM, documented it was a he said, she said type of situation, with both residents blaming each another for starting the verbal altercation.

Review of resident #3's record revealed the date of admission on . The 1823 Health Assessment form dated listed medical history of major , , , communication , type 2, , , in , and with spasms. The assessment noted she was independent with all ADLs and needed assistance with self-administration of medications.

Review of resident #4's record revealed the date of admission as . The 1823 Health Assessment form dated listed medical history of memory loss (short term), and decrease in vision. He ambulated with his electric wheelchair and was independent with all ADLs and needed assistance with self-administration of medications.

There was no facility notes documented about the verbal altercation between resident #3 and resident #4 on .

On at 4:55 PM, an interview with the Administrator confirmed there were no facility

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A 025	Continued From page 5 notes documented for the verbal altercation between resident #3 and resident #4 on and that she submitted an adverse incident report to the agency and was provided with the local law enforcement business card with the case number. On at 12:30 PM, during a telephone exit interview, the Administrator confirmed the findings. (Photographic Evidence Obtained) Class III	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all	A 030		

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A 030	Continued From page 6 residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with	A 030		

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A 030	Continued From page 7 convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.	A 030		

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A 030	Continued From page 8 (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the	A 030		

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A 030	Continued From page 9 case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state	A 030		

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A 030	Continued From page 10	A 030		

that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

This Statute or Rule is not met as evidenced by:
Based on the facility's documentation, resident

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A 030	Continued From page 11 record review and interview, the facility failed to honor resident rights for 1 of 4 sampled residents who was found unresponsive and ( ) was not initiated as required for resident #1 who was identified as Full Code at the assisted living facility. Findings: Review of resident #1's record revealed she was admitted to the facility on . The last 1823 Health Assessment form dated listed medical history of , carotid , and . The assessment noted she ambulated with a wheelchair and needed assistance with self-administration of medications. The assessment form noted resident #1 was independent with all her activities of daily living (ADLs) and required no additional assistance. Review of a facility note dated at 8:44 AM, by Caregiver B documented resident #1 complained of and reported she had and complained that her left arm felt strange. The facility called 911 and she was transferred to the hospital to be evaluated. The family, physician and management staff were notified of resident #1's transfer to hospital. Review of the hospital discharge note dated revealed resident #1 was treated for during her stay in hospital. She was discharged from the hospital and returned to the facility on . Review of the facility's incident report dated the next day, at 5:45 AM, revealed	A 030		

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A 030	Continued From page 12 Unlicensed Caregiver A went to resident #1's apartment to complete a Medication Pass that was due at 6 AM. She knocked on the door and entered resident #1's apartment, calling out good morning but the resident did not respond. Unlicensed Caregiver A went to resident #1's bedroom first and did not see her in bed, so she went to check the bathroom. She opened the bathroom door and saw the resident hunched over and wedged in between the bathroom sink and a small dresser. The resident did not respond and her skin color appeared bluish. The report showed Unlicensed Caregiver A stated she called 911 immediately at about 5:45 AM and was told by the 911 dispatcher not to touch the body and not to touch anything in the apartment. At 5:47 AM, the local police arrived at the facility, and shortly thereafter at 5:50 AM, Emergency Medical Services ( ) arrived and used defibrillator and Automated External Defibrillator ( ) machine for the next 10 minutes. Unlicensed Caregiver A noted that resident #1 was pronounced at the facility. The report noted Caregiver A did not call for additional assistance from the other staff (Caregiver F) that were working that shift with her. There were no nurses working round the clock at the facility. Review of the ( ) list did not show resident #1's name which indicated she was a full code. There was no documented evidence of facility notes regarding this incident on in the file and there was no documentation the facility conducted an internal investigation regarding this incident. A review of the facility's	A 030		

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A 030	Continued From page 13 ( ) policy, dated documented to: 1. Call 911 immediately. 2. Pull the residents' chart to verify a . 3. If a properly executed exists, withhold . 4. If a does not exist, perform . 5. Not applicable (n/a) regarding Hospice residents. 6. Contact the facility manager or designee to report the incident. 7. Properly document the incident all actions taken in the resident record, including date and time resident was found, the time of emergency medical personnel were called, time was initiated or withheld and time the physician and family were notified. 8. Complete an Incident Report. A review was done of the facility's list of all the residents that had full code and status. The facility census was 94, with 66 residents that were Full code and 28 residents that had 's. There was no documented evidence that Unlicensed Caregiver A immediately initiated to resident #1 after verifying resident #1 did not have a on at 5:45 AM in accordance with the facility's policy notated above. During the time when Unlicensed Caregiver A found resident #1 unresponsive in the bathroom hunched over and wedged in between the bathroom sink and the small dresser, she did not call on other staff to assist her. She did not initiate as per the resident's wishes and as per policy. Instead, Unlicensed Caregiver A called 911 the other Caregiver F to assist, also working during this time to call 911 while Unlicensed	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966084	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 14 Caregiver could initiate to resident #1. Unlicensed Caregiver A only called 911, not proceeding to follow the facility's policy step #4 and stated that the 911 dispatcher told her not to touch the body and not to touch anything in resident #1's apartment during that call. A review of the 911 call dispatcher transcript of which most were redacted showed the following: a) at 5:40 AM, 911 dispatcher received call from Unlicensed Caregiver A saying a female patient on the floor and to touch. b) at 5:41 AM, police arrived at the facility to a , female not , not breathing, and and stiff in a warm environment. c) at 5:42 AM, Emergency Medical Services arrived at the facility, initiating the defibrillator and machine for 10 minutes. d) at 6:07 AM, both police and left the facility. There was no additional information documented regarding time of and disposition of resident #1 from this transcript. There was no evidence that the 911 operator instructed Caregiver A not to touch the body. On at 2:21 PM, the Administrator was questioned as to why Unlicensed Caregiver A did not initiate to resident #1. The Administrator stated that Caregiver A was following the directives of the 911 dispatcher telling her not to touch the body and not touch anything in the apartment. The Administrator acknowledged Unlicensed Caregiver A did not follow the facility's	A 030		

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A 030	Continued From page 15 policy, step #4 to initiate and perform on resident #1. On at 3:47 PM, during a telephone interview, Unlicensed Caregiver A stated that on at approximately 5:45 AM, she went to resident #1's apartment to complete a Med Pass for medications due at 6 AM. She said she knocked on the door and entered the apartment, calling out to resident #1 and did not get any response. She explained she went to resident #1's bedroom and the resident was not in her bed, so she went to check the bathroom. She stated she found resident #1 hunched over and wedged in between the bathroom sink and a small dresser. Caregiver A said resident #1 was not responding, nor breathing and her skin was bluish color. She said she checked for , and checked if resident was breathing before she called 911. When asked why she did not initiate and perform when she found resident #1 not responsive in the bathroom, she replied the 911 dispatcher told her not to touch the body and not to touch anything in the apartment. She said she followed the 911 dispatcher's instructions because they had more experience with this kind of situation and thought they were higher chain of command than the facility. Unlicensed Caregiver A said that she was aware of the facility's policy, step #4 and had training in . She added, she did not panic during this incident, and that she had seen before but not for one of her residents in an assisted living facility. She said she was very familiar with resident #1 who had just returned from the hospital from surgery the day before on . Unlicensed Caregiver A stated that she helped resident #1 get ready for bed at about 12 AM midnight on and assisted with putting on her pajamas and putting	A 030		

Agency for Health Care Administration

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A 030	Continued From page 16 her , dog in the bed beside her. Review of Unlicensed Caregiver A's personnel record revealed she was hired on and had valid certification training with expiration date of . On at 12:30 PM, during a telephone exit, the Administrator confirmed the findings. (Photographic Evidence Obtained) Class I	A 030		