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
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 #2025016385 was conducted on at Palmetto Landing Winter Springs. The facility has a deficiency at the time of the visit.	A 000		
A 030 SS=D	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 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.	A 030		

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
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 1 (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 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.	A 030		

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
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 2 429.28 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. (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.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 3 (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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 4 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 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 5 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 record review, interviews and observations the facility did not ensure residents were restrained while sitting in the wheelchair by using a tie from the residents bath robe for 1 of 3 sampled residents by using a on resident #1. Findings: A review of resident#1's admission and health records confirmed an admission date of	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 6 into the secure memory care unit. Resident#1's health assessment dated revealed a medical history of of right , , non lymphoma in remission, , Aphasia, and generalized , . Resident#1 required assistance with daily living to include assistance with ambulation, eating, transferring, bathing, , self-care, toileting and assistance with medications. A review of the facility notes dated states the following: the nurse on duty was advised by the caregiver to come to the memory care unit because she found resident#1 tied to the resident's recliner with a tie from a bathrobe. The caregiver stated she was doing her rounds in memory care and noted that resident#1 was watching TV in her recliner, which faces the opposite direction of the door to the room. Therefore she did not notice the resident tied to the recliner at that time. The caregiver then stated that later that day when she went in to get the resident ready for dinner, she noticed that the resident was tied with a tie from her bathrobe to chair. The observation note states that the nurse then was called and the resident was assessed with no injuries, distress or , . The observation note states after the incident the resident went in to the dining area and ate dinner. In an observation on at 10 AM, resident#1 was participating in activities in the common area and did not seem distressed. The resident appeared bathed and groomed appropriately. She was non verbal and could not respond to any of this surveyor's questions. In a review of the facility's , neglect and , policy, it states to establish a commitment to quality care and	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 7	A 030		

prevention, as well as culture that encourages reporting and follow through on all allegations. Establish investigative procedures. Complete summary of investigation, work with all law enforcement and state agencies for their portion of the investigation. Staff who receive initial allegation of will be removed from duties, implement corrective actions and promote quality of care.

In a review of unlicensed staff A's personnel file it states the following: date of hire , background check , , Neglect and , training . Corrective actions during employment and after the incident included:

Associate was discharged after suspension on and the internal investigation for on a resident. Termination as of .

associate was observed to have pre poured a medication cream that she left behind on the laptop unattended while she went to apply a medication cream to another resident.

/ 24 Associate failed to perform a proper count at the beginning of her shift with the off going med tech from night shift. She did not follow proper protocol which resulted in medication missing off the cart.

Associate gave the wrong and wrong dose to a resident in the memory care unit that was for another resident.

Associate spent hours in memory care sitting in the activity room with other staff talking about non work related topics which staff were not to be able to conduct their job duties.

Associate left from her shift at 9 AM she did not communicate with management the fact that she needed to leave.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 8 In an interview on at 10:15 AM with the Wellness Director, she stated the incident was not discovered until about 4pm because when the shift change happened at 2pm the staff checked on resident #1 but she was in her TV chair, in her room, which has a high and faces the window. She stated when staff looked in on her they only saw her looking at the TV with a doll in her arm. She stated they did not see the tie around her until dinner was served in her room. She stated the nurse (staff B) examined her immediately after being notified of the incident. The resident had incurred no injuries and was cheerful and not in distress. In an interview on at 11:10AM with staff B, he stated he was working that day and they just did a shift change at 2pm. Around 4 pm he was notified by staff that resident #1 was tied to her chair and a rope around under her . He stated he immediately went to the room and did a skin check. There was no or redness or any injury to the resident. He stated she did not realize she was tied to the chair from his observation. He stated however, she is nonverbal. He stated resident#1 is a but mostly walking around memory care hallways. She is not aggressive or to anyone and follows directions and redirections. In an interview on at 11:15 AM with staff C, she stated the resident in memory care unit are checked on every 2 hours. She stated she did not know why the staff did not notice the ties on resident #1. She stated staff A was terminated for the action she took. She stated there is always enough staff in the memory care unit so there is no excuse why this should have happened as staff A could have asked for assistance if she needed it. She stated restraining	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 9 is something we never do and is a form of and neglect. She stated resident #1 is easily redirected and she likes to walk the halls of the memory care. She stated she is not difficult or aggressive in any way. In an interview on at 11:25 AM with staff D she stated 2-hour checks are completed round the clock in memory care sometimes more if the resident needs it. She stated resident #1 has her chair for TV faced to the window so when you walk in her room you would not be able to see if there was a rope tied on her. She stated there is always 3 caregivers on the floor in memory care and the full time nurse is available to assist. She stated resident #1 is a very pleasant person and listens to directions and easily redirected. In an interview on at 10:15 AM with the Wellness Director, She stated the incident was not discovered until about 4pm because when the shift change happened at 2PM the staff checked on resident #1 but she was in her TV char which has a high and faces the window. She stated when staff looked in on her they only saw her looking at the TV with a doll in her arm. She stated they did not see the tie around her until dinner was served in her room. She stated staff B examined her immediately after being notified of the incident. The resident did not incur any injuries and was cheerful and not in distress. In an interview on at 11:30 AM with the Memory Care Director, he stated around 3 or 4 PM we were notified by staff in memory care that resident #1 was tied to her chair by a rope or belt. Staff B assessed her for injuries and did a skin check and no injuries were present. Resident #1 was not under distress and she was fine mentally.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 10	A 030		

She probably did not realize that she was tied to the chair. He stated the staff did not notice her until about 4 pm because when they checked on her at 2 PM at the beginning of the shift she was in her room watching TV with her chair facing the opposite direction and they could not see the rope on her. Resident #1 is a pleasant person, and she like to walk the halls, she is not aggressive in any way. He stated staff A immediately was called and she admitted to using the tie from the bathrobe to restrain the resident because she stated the housekeeper was mopping the floor and she didn't want the resident to trip on a wet floor. Staff A was suspended immediately, and we did an internal investigation and notified the Department of Children and Families. Staff A was terminated from her position after the internal investigation was completed. He stated staff A has never done anything like this before and he was very surprised this incident happened.

In an interview on at 11:45 AM, with staff E he stated resident #1 is not aggressive in her behaviors and she is easily guided or re directed. He stated resident #1 likes to the halls but she is one of the easier residents to care for and could not understand why this incident happened. He stated there is more than enough staff to care for the residents in memory care and there is always staff and management to assist if it is needed. He stated we never restrain any resident regardless of their behaviors.

In an interview on at 12 PM with the family member of resident #1, she stated she does not see it as a /neglect issue. She stated she feels it was a lapse of judgement. She stated it was unfortunate and disappointing. She stated staff A was her favorite staff and always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 11	A 030		

took very good care of her family member. She stated she had seen staff A that morning and she seemed frazzled. She stated she herself has been interviewed by all agencies and law enforcement and has stated the same thing and is not pressing charges. She stated it is hard to say if her mom (resident #1) was upset about the incident because she is nonverbal. She stated the facility handled the incident very well and was on top of it. She stated she has no issues with supervision, quality of care/treatment, or neglect for mother residing at the facility.

In an interview on at 2 PM with staff F, she stated on at 2pm, there was a shift change with staff A and she saw resident #1 in her chair in her room holding her baby doll and watching TV. She stated she did not see any strap visible. She stated at 4pm she walked to her room to give her dinner, she was sitting in her chair. She stated she walked up to her to help her stand up and that is when she pulled a strap from her and I realized she was tied to the chair. The strap was from her purple robe. She stated the nurse was called immediately and assessed the resident for injuries.

There was no documentation that staff was immediately trainined on the use of in an Assisted livng Facility.

In an interview on at 2:15 PM with the administrator, he stated he was not the administrator at the time of the incident but was aware of what had happened. He stated all the staff has since then had in service training for , neglect and , .

Photographic evidence obtained

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
	AL11964388	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 030	Continued From page 12 Class III	A 030		