

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970374	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER BAHAMA BAY CLUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3441 W. 1ST ST SANFORD, FL 32771		
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A 000	Initial Comments A complaint survey (#2026001524) was conducted at Bahama Bay Club assisted living facility on - . A deficiency was identified at the time of survey.	A 000			
A 030	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			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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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			

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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			

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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			

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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. (I) 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			

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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 interviews and record review, the facility failed to ensure residents' rights to live in a safe environment and free from , which resulted in 1 of 2 sampled residents being , requiring an admission to a hospital's emergency department (#2). Findings include: During the interview on at 2:15 PM, Staff D, a Medication Technician (MT), indicated	A 030			

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A 030	Continued From page 6 that she witnessed resident #1 becoming aggressive. She recalled that she was at the medication cart when she heard resident #1 threatening resident #2 to shoot him with a gun after resident #2 into resident #1's room. The MT indicated she submitted a written statement to the facility Administration. During the interview on at 2:45 pm, Staff B, the Assistant Director of Nursing (ADON), stated her functions included being a director of memory care unit. She indicated that after the incident, the facility put resident #2 on an individualized activities and 15-minutes checks to help him avoid contact with resident #1. The ADON indicated that Administration had multiple care plan meetings with resident #1's family and his Primary Care Provider (PCP). The PCP offered to put resident #1 on medications for his aggressive behavior, but his family refused. The ADON indicated that resident #1 was always verbally aggressive and agitated frequently calling staff and residents names. She indicated she recalls the incident when resident #1 threatened resident #2 to kill him with a gun During the interview on at 3:20 PM, Staff A, a MT, she indicated she was on duty in the memory care unit on doing rounds, and recalled when she checked on resident #1, he told her, "Don't close my f***ing door and get out of my f***ing room". She repeated, he responded "Don't lock my f***ing door. Get the f*** out". Soon after, Staff A was gathering trash and tried to re-approach resident #1 about locking his door to avoid resident #2 into his room. Resident #1 grabbed the apartment room's door and told her to "get out of my f***ing room you f***ing b***h". Staff A also indicated later she was running errands in the	A 030			

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A 030	Continued From page 7 memory care unit and heard resident #1 telling someone to get out of his room and threatening to smash their . Before she was able to get to the room, she heard resident #1 saying "I told I would punch you". Staff A witnessed resident #1 hitting resident #2's and . Staff A then grabbed resident #2 to pull him away from the assault. Resident #1 said "I gonna beat his f***ing brains out". Staff A called the supervisor and 911. She reported that resident #2's looked crooked and . When police came, they interviewed resident #1. Staff A indicated resident #1 had always been aggressive towards her and others. He had previously told staff A that he would punch her and would call her the "n" word. A review of resident #2s facility records revealed he was a male who was admitted on to the memory care unit. His diagnosis included previous lacunar infarct and short-term memory loss. A review of the Agency for Health Care Administration (AHCA) form 1823, Health Assessment, revealed resident #2 was independent with ambulation and did not pose a danger to self or others. A review of the hospital discharge records for resident #2 revealed, that on were seen today for: assault, bone , closed injury (photographic evidence obtained). A review of the facility's resident records revealed that on : a 45-day discharge notice to vacate for the premises was issued for resident #1 due to previously addressed aggressive behavior. Additionally, there was a request to arrange private aide to provide supervision for resident #1 during all waking hours. A review of the facility's admissions and discharge log revealed: Resident #1 was admitted on and discharged on .	A 030			

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A 030	Continued From page 8 A review of resident #1's progress notes revealed " : Seen today by Primary Care Provider as requested by community for increased verbal aggression noted on Resident yelling at staff and other residents balling his fist at another resident threatening to hit her. New orders received and processed. Daughter updated by facility and PCP spoke to her via phone. : Daughter reached out to this nurse writer late in the evening on concerned with the new medications prescribed ... Medications have been put on hold per daughter's refusal until PCP has reviewed recent hospital paperwork. Care staff were notified to communicate any aggressive behavior to on call nurses so the daughter can be notified immediately and has been informed she may need to stay with the resident in the event of incident until there is resolution of the aggressive behaviors. : Late entry: Care staff reported at approximately 3:45pm resident (#1) was becoming verbally and physically aggressive. Staff reports resident got up and tried changing the channel on the living room television while other residents were watching. Staff tried to redirect the resident (#1) to his room to watch football. Resident (#1) then became verbally aggressive by yelling at the staff. Staff removed themselves to the kitchen area and the resident (#1) self-propelled his wheelchair to the kitchen further confronting the staff member. When the resident (#1) reached the kitchen, he rose from his wheelchair in a threatening manner and lunged his body at the care staff. The counter was between resident (#1) and the staff member.	A 030			

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A 030	Continued From page 9 so no contact was made. Resident (#1) then left the kitchen and continued with verbal aggression towards other residents. Daughter notified and PCP notified. PCP and daughter talked further this morning, and new orders received and processed. Late entry: Care plan meeting with Executive Director, Staff B, resident #1's family, PCP, and the nurse writer. It was noted that there are no specific triggers that caused the behavior and redirection does not work to de-escalate ... Daughter refused initial med treatment ordered on . Medications were placed on hold per daughter's request until PCP spoke to her. PCP and daughter agree to a low dose [, , medication] (prescription medications used to treat , symptoms, such as and others) to help with . changes. 2:45 PM Resident (#1) was sitting at the community dining room table with another resident talking. Resident (#1) became agitated with the conversation and stood up from his wheelchair, pulled his fist and threatened to strike the other resident but action was interrupted by [memory care unit] staff. The other resident was safely escorted to her apartment. Resident (#1) then commented that he will be "watching her" as [memory care staff] attempted to de-escalate and redirect. [Health and Wellness Director] and PCP made aware. Late entry: Resident (#1) seen today by Primary Care Provider for ongoing aggressive behaviors. New medications ordered a discussed in the care plan meeting with the daughter, PCP, Executive Director, and Health and Wellness Director ... Daughter agreed to increase dose with	A 030			

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A 030	Continued From page 10 another dose increase to follow later. : Late Entry for 9:46 PM; Reported to this nurse writer the following by staff assigned to [memory care unit] on the evening of at 9:46 pm. Staff were in the common area with other residents when they heard talking between resident #1 and another resident. Resident #1's verbiage began to escalate. Staff got up and witnessed resident #1 and another resident in the hallway. Resident #1 was hitting the other resident in the and . Staff had to remove the other resident from resident#1's reach to stop the ongoing incident ... : Late entry At approximately 4:10pm [Executive Director], [Health and Wellness Director], Staff B, resident #1's family, and PCP met for a care plan meeting regarding the incident on ... Adjunct discussed to which daughter refused. Continues to only agree to increase dose of [medication] to 15 mg daily on next PCP's visit date ... Discussed previous redirection suggestions to which [Executive Director] and [Health and Wellness Director] stated are not effective... [Executive Director] and [Health and Wellness Director] discussed several staff complaints of fear and resident verbal statements of fear towards resident due to his aggressive verbal and threats of physical ... Several options were discussed to accommodate the resident #1 going forward to a possible room change, and it was denied due to location. Strategies for maintaining effective supervision of the resident in question were also discussed. : Late Entry for 4:00 PM: Executive Director called and spoke with [Power of Attorney] explaining the need for a daytime	A 030			

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A 030	Continued From page 11 caregiver to watch resident #1 to make sure he does not harm anyone else. Executive Director also explained he is sending the 45-day notice. : Resident moved out ..." (photographic evidence obtained) During an interview on at 9:30 AM with the Executive Director, she stated that after the incident between resident #1 and resident #2 the facility did not discharge immediately after the assault but reached out to resident #1's family with request to provide a one-on-one supervision to avoid future assaults. During the interview on at 10:30 AM, the PCP stated resident #1 was first admitted to independent living section of the facility but was moved to memory care as he was getting more forgetful. She indicated he was "ok-ish" when he was first moved to the memory care unit. He always had a "harsh , , ." but was never physically aggressive. Approximately mid- he became more verbally aggressive. PCP suggested to put him on [, , , medication], his daughter declined. PCP managed to convince the daughter to start treatment with an { , , , medication} on a sub-therapeutic dosage 5 mg (therapeutic dosage starts with 15 mg). This dose did not have any effect, and she agreed with the family to increase the dose to 10 mg, which had limited effect. PCP talked to the daughter and wanted to increase the dose to 15 mg, but the daughter insisted to stay on 10 mg for one more week, when the assault happened. When asked if she considered if resident #1 ever was harmful to self or others, PCP stated that resident #1 was always verbally aggressive. Given the physical assault has happened, he caused harm to others.	A 030			

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A 030	Continued From page 12 During the interview on _____ at 11:00 am, Executive Director stated that nothing specific was done at the memory care unit level to assess the appropriateness of memory care unit residents for continued residency at the facility given it was an _____ incident. Review of the facility's policy on admissions - continued residency revealed "the owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility ..." (photographic evidence obtained). Review of the facility's policy on _____ revealed "Bahama Bay Club takes all reasonable steps to prevent resident _____ and neglect" (photographic evidence obtained). Class II	A 030			