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
	AL11967569	A. BUILDING: _____ B. WING _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF TITUSVILLE	497 N WASHINGTON AVE TITUSVILLE, FL 32796

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A 000	Initial Comments Complaint survey #2026004924 was conducted at Addington Place of Titusville on , , , and . Class I deficiencies were identified at the time of survey. Class I deficiencies were identified for A0030 and A0077. 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 Class I noncompliance began on when the facility failed to conduct fire watches when the fire alarm system was , due to replacement. On , a fire occurred in a resident's room and staff were unaware. The resident was removed from his apartment by the fire department and transferred to a hospital with life threatening injuries. The resident at the hospital as a result of injuries sustained in the fire. The facility's Administrator was notified of the Class I noncompliance on at 12:52 PM. The census at the start of the survey was 75. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 (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. (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;	A 030		

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A 030	Continued From page 2 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. 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,	A 030		

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A 030	Continued From page 3 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. (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	A 030		

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A 030	Continued From page 4 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 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,	A 030		

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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 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

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A 030	Continued From page 6 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 observation, interview, and record review, the facility failed to conduct fire watches when the fire alarm system was , . The failure resulted in a fire in one (#12) resident's apartment and the evacuation of 35 other residents out of a total sample of 75 residents. Resident #12 was air lifted to a hospital with life threatening injuries and subsequently . Findings included: Review of facility emails, dated showed the facility's Project Associate emailed the Maintenance Director that fire watches needed to be arranged as the fire control panel was to be upgraded beginning with project timeline ranging from 5 to 8 weeks. The email reported the facility needed to arrange fire watches for the duration of the project. On the	A 030		

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A 030	Continued From page 7 Maintenance Director forwarded the email to the Administrator. On the Administrator responded and asked the Maintenance Director to find out what fire watch meant. On the facility's National Director of Plant Operations sent an email to both the Administrator and the Maintenance Director that had the fire watch policy and log attached. The email went on to show that whenever an area of the fire system is , or out of service, a staff member acts as the fire detector. They patrol the area and sign off on the log sheet after every round made. Once the system is online, the watch is over. The fire watch policy, dated , indicated that a protocol was in place in the event the fire alarm system became , . The policy indicated the primary role of the fire watch personnel was to be a "human smoke detector." The procedures outlined fire watch instructions to conduct a continuous patrol of all designated areas at least once every 30 minutes. Look for observable signs of smoke, fire, and hazardous conditions. Enter all stairwells-open doors and look in each stairwell. Enter all common areas including basements, lounges, laundry rooms, and dining areas. At the first sign of smoke or fire, the fire watch personnel must pull the nearest fire alarm pull station. If the fire alarm horns are not working, use the megaphone or air horn to notify the building occupants to evacuate. Review of the facility's fire watch log dated , revealed a fire watch was done every hour from 9:48 PM until 6:35 AM. There was no documentation to show any additional fire watches were conducted prior to the fire that occurred on . A progress note, dated at 12:40 PM,	A 030		

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showed a fire was reported in Resident #12's room. The note revealed staff did not enter the room due to active fire and smoke. The note showed the fire department arrived and removed the resident from the room. The note read, the resident was transported to the hospital for possible smoke inhalation.

Review of hospital records revealed the resident arrived via helicopter on at approximately 2 AM. Findings included grade 1 inhalation injury (heat injury restricted to upper airway structures), acute failure with hypercapnia (excessively high levels of in the stream), Glasgow scale of 3 (deep , , or profound ,), right , singed hairs, / , no evidence of soot in the airway.

During an interview on at 4:26 PM, Resident #12's family member said the resident , , in the hospital from injuries sustained in the fire.

Observations made on at 9:15 AM revealed repairs for water damage were being done in the hallway where Residents #1, #2, #3, #6, #7, #9, #11, and #12 lived. Resident #12's room was sealed closed. The Director of Nursing (DON) said that room could not be entered due to a fire investigation.

During an interview with Caregiver C on at 5:18 PM, she said that on between approximately 12:30 AM to 12:45 AM, she saw water in the hallway. She recalled she called out to Caregiver A who was nearby. She said Caregiver A opened Resident #12's room, and they saw smoke and heard popping sounds.

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A 030	Continued From page 9 Caregiver C said she heard Resident #12 yelling. She said she began evacuating residents from nearby apartments. Caregiver C said the fire alarm did not sound. She remembered that approximately 30 to 40 minutes before seeing the water, Caregiver A alerted her to an alarm sounding in the outside courtyard of Orchard, one of the memory care units. Caregiver C said she did not know the source of the alarm. On at 6:45 PM, Caregiver C said she did not know why she did not pull a fire alarm and did not get a fire extinguisher. Caregiver C reported she and Caregiver A panicked. She explained she did not enter Resident #12's room. She just started getting other residents out. During an interview with Caregiver A on at 5 PM, she said that on at approximately 12 AM she gave medications to Resident #9, who lived next door to Resident #12. She stated there was no water at that time and no cause for concern. Caregiver A said that at approximately 12:39 AM she heard an alarm sounding in the outside courtyard of Orchard. She recalled she called the Maintenance Director and told him an alarm was sounding. Caregiver A said that at 12:49 AM, Caregiver C told her there was water in the hallway and she called the Maintenance Director and told him about the water. She then saw water pouring from under Resident #12's room. Caregiver A said she opened Resident #12's room door and was met by smoke and heat and heard something pop. She recalled she did not close the room door because she was scared and felt bad closing the door with Resident #12 still in the room. Caregiver A said she then called 911 and the fire department arrived. She stated firemen entered the room, removed Resident #12, and evacuated additional residents. Caregiver A said the fire	A 030		

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A 030	Continued From page 10 alarm did not sound. Caregiver A said she did not hear any fire alarm sound, and she did not pull a fire alarm or get a fire extinguisher because she called 911. During an interview with the Maintenance Director on at 2:40 PM, he said the alarm heard by Caregivers A and C was the sprinkler system alerting to its engagement. The Maintenance Director said the sprinkler system was in the fire riser room located behind Orchard unit. He explained the fire system was being replaced at the time of the fire because the current one was obsolete and false fire alarms and ineffective strobe lights occurred. The Maintenance Director said he did not know the fire alarms were not working prior to the fire. He noted he saw the email that directed fire watches to be done and he forwarded it to the Administrator. The Maintenance Director said each resident room had a fire alarm and sprinklers and there were 1 to 2 fire extinguishers in each hallway. During an interview with Caregiver D on at 4:30 PM, she said she worked in Orchard at the time of the fire. She recalled she heard a faint sounding alarm in the courtyard and did not know what it was. Caregiver D said the fire alarm did not sound and she learned there was a fire when she saw smoke and firemen in the facility. During an interview with Caregiver B on at 3:57 PM, she said she worked in Groves, the other memory care unit, at the time of the fire. Caregiver B said she learned there was a fire when Caregiver C told her residents had to be evacuated. During an interview with the Administrator on at 11:27 AM, she said the facility's fire	A 030		

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A 030	Continued From page 11 alarm system was being updated at the time of the fire, and she was unaware the fire alarm was not working. The Administrator said someone, she did not know who, was investigating why the fire alarm did not sound. She stated cameras in the hallway captured the incident but she did not review the video footage because the system was too complicated. On at 5:37 PM, the Administrator said she did a fire watch only on , and she did not know the fire watch was to be done during the duration of the fire panel being . . She said she read the email too fast and thought fire watch was only to be done for that day. On at 10:55 AM, the Director of Nursing (DON) said that at the time of the fire, the total resident census was 75. She stated all 35 assisted living residents were evacuated. The remaining residents lived in memory care and did not have to be evacuated. On at 9:26 AM, Resident #1 said a fire alarm did not sound. The resident stated a fireman told him to evacuate. During an interview with Resident #2 on at 9:31 AM, she said she was asleep when she was awoken to people screaming. The resident recalled someone saying, "water, water." She said she smelled smoke and when she opened her room door, someone told her to get out. The resident said she was taken to the memory care unit. The resident explained work was being done on the fire system at the time of the fire, and she did not hear any alarm. She said she experienced soreness and and watery . . During an interview with Resident #3 on at 9:45 AM, she said she woke up and went to	A 030		

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A 030	Continued From page 12 the bathroom, and saw water on the bathroom floor. She recalled she pressed her emergency pendant and someone responded and told her to get out of her room. She stated there was smoke in the hallway when she went to the dining room. Someone then told her to go outside, where she sat for two hours. The resident said she could not recall hearing a fire alarm. During an interview with Resident #6 on at 10:01 AM, she said the fire alarm did not sound. During an interview with Resident #7 on at 10:10 AM, she said she got out of bed that night, opened her door, and then saw water. She said she did not hear any alarms, and she was evacuated outside. During an interview with Resident #9 on at 10:25 AM, she said at about 12 AM she was asleep when she heard a woman scream. She recalled that about 10 minutes later, her room door burst open and two men wearing what looked like space gear, entered her room and shouted, "is anyone here?" She said she did not say anything because she did not know who they were. She stated the men left her room and 30 minutes later, 4 or 5 firemen entered her room and removed her from the room in a wheelchair and took her outside. The resident said the fire alarm did not sound. She did not see smoke until the second time her door was opened. The resident said she was wearing at the time of the fire. During an interview with Resident #11's family member on at 8:57 AM, the family member said the resident had and used	A 030		

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A 030	Continued From page 13 . Resident #11 was evacuated during the fire, and her room is being repaired due to damages sustained during the incident. Resident #11 has chosen to stay with family during the repair and fire investigation. Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	A 077		

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A 077	Continued From page 14 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the	A 077		

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A 077	Continued From page 15 individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which	A 077		

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A 077	Continued From page 16 is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility's Administrator failed to ensure a fire watch was conducted when the fire alarm system was , due to repairs, failed to conduct a thorough investigation, failed to ensure staff were competent in responding to fire and emergency procedures and trained to recognize alarms, failed to ensure the facility had an annual fire inspection, and failed to ensure the facility acquired and installed a monoxide detector for the protection of 75 sampled residents. As a result of these failures, a fire started in Resident #12's room on . The resident sustained life threatening injuries and subsequently . Findings included: Observations made on at 9:15 AM, revealed repairs for water damage were being done in the hallway where Residents #1, #2, #3, #6, #7, #8, #9, #10, #11, and #12 lived. Resident #12's room was sealed closed. The Director of Nursing (DON) said the room could not be entered due to a fire investigation. A progress note, dated at 12:40 PM, indicated a fire was reported in Resident #12's room. The note showed staff did not enter the room due to active fire and smoke in the room. The note showed the fire department arrived and removed the resident from the room. The	A 077		

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A 077	Continued From page 17 resident was transported to a hospital for possible smoke inhalation. Review of facility emails, dated revealed the facility's Project Associate emailed the Director of Maintenance (DOM) to inform the DOM that fire watches needed to be arranged as the fire control panel was to be upgraded beginning with project timeline ranging from 5 to 8 weeks. The email reported the facility needed to arrange fire watches for the duration of the project. On , the DOM forwarded the email to the Administrator. On , the Administrator responded and asked the DOM to find out what fire watch meant. On , the facility's National Director of Plant Operations sent an email to both the Administrator and the DOM that had the fire watch policy and log attached. The email documented that whenever an area of the fire system is , or out of service, a staff member acts as the fire detector. They patrol the area and sign off on the log sheet after every round made. Once the system is online, the watch is over. Review of a fire watch log, dated , revealed a fire watch was done hourly from 9:48 PM until 6:35 AM. This was the only time period in which a fire watch was conducted prior to the fire that occurred on . During an interview with Caregiver C on at 5:18 PM, she said that on between approximately 12:30 AM to 12:45 AM, she saw water in the hallway. She remembered calling out to Caregiver A who was nearby. She said Caregiver A opened Resident #12's room. They saw smoke and heard popping sounds. Caregiver C said she heard Resident #12 yelling. She said she began evacuating residents from nearby	A 077		

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A 077	Continued From page 18	A 077		

apartments. Caregiver C said the fire alarm did not sound. She remembered that approximately 30 to 40 minutes before seeing the water, Caregiver A alerted her to an alarm sounding in the outside courtyard of Orchard, one of the memory care units. Caregiver C said she did not know the source of the alarm. She said that upon hire, she received fire training through distant learning (computerized training). Caregiver C said she did not receive training on the comprehensive emergency management plan, which included training on what to do in the event of a fire. She stated she did not receive post incident training. On at 6:45 PM, Caregiver C said she did not know why she did not pull a fire alarm and did not get a fire extinguisher. She explained she just started getting people out. She reported that she and Caregiver A panicked.

During an interview with Caregiver A on at 5 PM, she said on at approximately 12 AM she gave medications to Resident #9, who lived next door to Resident #12. She stated there was no water at that time and no cause for concern. Caregiver A said at approximately 12:39 AM she heard an alarm sounding in the outside courtyard of Orchard. She called the DOM and told him an alarm was sounding. Caregiver A said that at 12:49 AM, Caregiver C told her there was water in the hallway. She called the DOM and told him about the water. She then saw water pouring from under Resident #12's room. Caregiver A said she opened Resident #12's room door and was met by smoke, heat, and heard something pop. She did not close Resident #12's door because she was scared and felt bad closing the door with Resident #12 still in the room. Caregiver A said she called 911, and the fire department arrived. She stated firemen entered

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A 077	Continued From page 19 the room, removed Resident #12, and evacuated additional residents. Caregiver A said the fire alarm did not sound. Caregiver A said she did not hear any fire alarm sound and she did not pull a fire alarm or get a fire extinguisher because she called 911. She stated she received fire training through distant learning (computerized training) upon hire. She recalled the DOM showed her where the fire alarms and fire exits were located. Caregiver A said she learned about the acronym R.A.C.E. (rescue, alarm, contain, extinguish or evacuate) and the location of fire extinguishers today, 3 days after the event, when the Memory Care Director called her. Caregiver A said she did not receive post incident training. During an interview with the DOM on at 2:40 PM, he said the alarm heard in the outside courtyard by Orchard by Caregivers A and C was the sprinkler system alerting to its engagement. The Maintenance Director said the sprinkler system was in the fire riser room located behind the Orchard unit. He recalled Caregiver A called him and told him where the alarm was sounding. He stated Caregiver A called him again and said there was water everywhere. He said he told Caregiver A to call the fire department. The DOM said that within 30 seconds, Caregiver A called him again and said there was fire and smoke. He said he told Caregiver A again to call the fire department. He explained the fire alarm system was being replaced at the time of the fire because the current one was obsolete. The DOM said he did not know the fire alarms were not working prior to the fire. He noted he saw the email that directed fire watches to be done, and he forwarded the emails to the Administrator. He stated each resident room had a fire alarm and sprinklers and there were 1 to 2 fire extinguishers in each hallway. On at 4:21 PM, the DOM	A 077		

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A 077	Continued From page 20	A 077		

said that upon hire, he gave new hires a tour and showed them where the fire extinguishers, fire alarm pull stations, exit doors, water shut-off valves, sprinkler heads, strobe lights, and fire alarms were located. He acknowledged he had not provided fire response training.

During an interview with Caregiver D on at 4:30 PM, she said she worked on the Orchard unit at the time of the fire. She she did not hear any fire alarm on the day the fire occurred. She stated she received fire training upon hire and explained in the event of a fire you first call the fire department, then evacuate the residents who are close to danger. Caregiver D said she did not receive post incident training.

During an interview with Caregiver B on at 3:57 PM, she said she worked on the Groves unit at the time of the fire. She said she first learned there was something wrong when Caregiver C told her the residents had to be evacuated. She said a fire alarm did not sound. She recalled that when she tried to open the exit door it was locked, which she found strange because she thought they automatically unlocked when there was a fire. Caregiver B said that in the event of a fire, don't touch the door if it's hot and if it's an electrical fire, use a fire extinguisher. She stated she did not receive post incident training.

During an interview with the Administrator on at 11:27 AM, she said the facility's fire alarm system was being updated at the time of the fire. The Administrator said she did not know the fire alarm was not working prior to the fire. She explained someone was investigating why the fire alarm did not sound but did not know who. The Administrator said her investigation and follow-up thus far was that she spoke with

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A 077	Continued From page 21	A 077		

Caregiver A and she printed the fire policies and handed them out, along with a quiz, to staff as they arrived at work. The Administrator said in-person mandatory training was scheduled for next Wednesday (,). She explained cameras in the hallway captured the incident, but she had not viewed the video footage as the system was complicated. On at 5:37 PM, the Administrator said she did a fire watch only on because she read the email too fast and thought it was needed for only that day. The Administrator said she learned from the Maintenance Director today, , that the alarm heard by the caregivers was the sprinkler alarm and not a fire alarm as she initially thought.

On at 10:55 AM, the Director of Nursing (DON) said at the time of the fire the total resident census was 75. The DON said all 35 assisted living residents were evacuated and the remaining residents lived in the memory care unit and did not have to be evacuated.

Review of the fire inspection report revealed it was last conducted on , over 15 months prior to the incident. On at 2:14 PM, the DOM said an inspection had not been conducted since then. He could not remember if he called the fire department to follow up.

Review of the Comprehensive Emergency Management Plan and floor plan did not indicate any monoxide detectors in the facility. On at 4:26 PM, the DOM confirmed the facility did not have a monoxide detector. The Maintenance Director added that he spoke with a fire alarm company, and it was confirmed the fire alarms were not dual detectors with monoxide.

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A 077	Continued From page 22 Class I	A 077		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating	A 081		

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A 081	Continued From page 23 staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of	A 081		

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A 081	Continued From page 24 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.	A 081		

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A 081	Continued From page 25 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 4 of 4 sampled staff were trained in and understood the facility's emergency procedures, fire response, and recognition of alarm sounds (A, B, C, D). Findings included: A progress note, dated at 12:40 PM, indicated a fire was reported in Resident #12's room. The note reported that staff did not enter the room due to active fire and smoke. The note showed the Fire Department arrived and removed the resident from the room. The note showed the resident was transported to the hospital for smoke related injuries. During an interview with Caregiver C on at 5:18 PM, she said that on between approximately 12:30 AM to 12:45 AM, she saw water in the hallway. She recalled Caregiver A opened Resident #12's room, at which time Caregiver C saw smoke, heard popping sounds, and heard Resident #12 yelling. Caregiver C said she then began evacuating residents from nearby apartments. She explained that upon hire, she	A 081		

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A 081	Continued From page 26 received fire training through distant learning (computerized learning system) and had not received any training on the Comprehensive Emergency Management Plan, which included training on what to do in the event of a fire. She said she did not receive post fire training. On at 6:45 PM, Caregiver C said she did not pull a fire alarm nor get a fire extinguisher, and she did not explain why. She said she just started getting residents out of adjacent apartments. She reported that she and Caregiver A panicked. During an interview on at 5 PM, Caregiver A said that at 12:49 AM on , Caregiver C told her there was water in the hallway. Caregiver A said she then saw water pouring from under Resident #12's room. She recalled she opened the resident's door and was met by smoke, heat, and heard something pop. Caregiver A explained she did not close Resident #12's door because she was scared and felt bad closing the door with the resident still in the room. She then called 911. She stated firemen arrived, removed Resident #12 from his room, and evacuated additional residents. Caregiver A said she did not pull the fire alarm and did not get a fire extinguisher because she called 911. She reported receiving fire training through distant learning (computerized learning system) upon hire. She added that upon hire the Maintenance Director showed her where the fire alarms and fire exits were located. She reported she learned about the acronym R.A.C.E. (rescue, alarm, contain, extinguish or evacuate) and the location of fire extinguishers today when the Memory Care Director called her. Caregiver A said she did not receive post fire training. During an interview on at 4:21 PM, the Maintenance Director said upon hire, he gave	A 081		

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	AL11967569	A. BUILDING: _____ B. WING _____	04/07/2026

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A 081	Continued From page 27 newly hired staff a tour and showed them the fire extinguishers, fire alarm pull stations, exit doors, water shut-off valves, sprinkler heads, strobe lights, and fire alarms. The Maintenance Director said he did not give fire response training. During an interview on at 4:30 PM, Caregiver D said she received fire training upon hire. She explained in the event of a fire, you first call the fire department and then evacuated the residents close to danger. She stated she did not receive any post fire training. On at 3:57 PM, Caregiver B stated that in the event of a fire, no one should touch the door if it's hot and if it's an electrical fire, use a fire extinguisher. She said she did not receive any post fire training. Personnel record review revealed Caregiver A was hired on , Caregiver B on , Caregiver C was hired on , and Caregiver D on . The records showed the staff received a two-hour in-service orientation that included 40 minutes of training on emergency procedures, including fire safety. Class III	A 081		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this	A 160		

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A 160	Continued From page 28 section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C.	A 160		

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A 160	Continued From page 29 (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and	A 160		

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A 160	Continued From page 30 procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have an annual fire inspection. Findings included: Review of the fire inspection report revealed the inspection was conducted on . On at 2:14 PM, the Maintenance Director said an inspection had not been conducted since . He could not remember if he called the Fire Department to follow up. Class III	A 160		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency	A 200		

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A 200	Continued From page 31 environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply	A 200		

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A 200	Continued From page 32 shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from	A 200		

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A 200	Continued From page 33 flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions	A 200		

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A 200	Continued From page 34 to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and	A 200		

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A 200	Continued From page 35 implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than , , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment;	A 200		

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A 200	Continued From page 36 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive	A 200		

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A 200	Continued From page 37 emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to acquire an appropriately functioning monoxide detector.	A 200		

Agency for Health Care Administration

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A 200	Continued From page 38 Findings included: Review of a letter from the local Emergency Management agency revealed the Comprehensive Emergency Management Plan (CEMP) was approved on . Review of the CEMP and floor plan did not show the facility had a monoxide detector. During an interview on at 4:26 PM, the Maintenance Director confirmed the facility did not have a monoxide detector. The Maintenance Director added that he spoke with a fire alarm company, and it was confirmed the fire alarms were not dual detectors for monoxide. The Maintenance Director said the generator, kitchen, and water heater used gas. Class III	A 200		