

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/17/2026
NAME OF PROVIDER OR SUPPLIER EMERALD GARDENS PROPERTIES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 N 72 AVENUE PENSACOLA, FL 32506		
(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
{ZZ000}	Initial Comments	{ZZ000}		
{A 000}	Initial Comments On _____, an unannounced revisit survey was conducted at Emerald Gardens Home ALF, an assisted living facility in Pensacola, Florida. At the time of the survey, deficient practice remained uncorrected.	{A 000}		
{A 152} SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable _____ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, _____ or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,	{A 152}		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/17/2026
NAME OF PROVIDER OR SUPPLIER EMERALD GARDENS PROPERTIES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 N 72 AVENUE PENSACOLA, FL 32506		
(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 152}	Continued From page 1 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a safe and comfortable environment by ensuring a functioning air conditioning (AC) system in the 200 hallway. This has the potential to affect all residents living on this hallway. The findings include: On at approximately 11:20 AM, an observation was made of Resident #5's room in the presence of Staff F, Office Manager. The air conditioning vent was noted to be closed. Further observation revealed there was no window air conditioning unit installed in this room. During this observation, an interview was conducted with Staff F. Staff F confirmed that there was no AC unit present in Resident #5's room. She explained that the AC condenser serving the 200-hallway had not been functioning properly since . At that time, window AC units were installed as a temporary measure. She further stated that, in , due to the cooler winter weather, the wall units had been removed from each room on the 200-hallway so	{A 152}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/17/2026
NAME OF PROVIDER OR SUPPLIER EMERALD GARDENS PROPERTIES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 N 72 AVENUE PENSACOLA, FL 32506		
(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 152}	Continued From page 2 the window could be better sealed to prevent air from entering the rooms. She explained that the non-functioning AC condenser affected the entire 200-hallway, including seven residents' rooms, one room, and two shared bathrooms. Staff F further explained that a contractor had ordered parts to repair the AC condenser; however, the work had not been completed. She confirmed that after the parts had been ordered by the contractor, but there had been no follow up by the contractor regarding the repair of the broken AC condenser. On at approximately 11:34 AM, an interview was conducted with Staff G, Maintenance Director. Staff G stated that the AC in the 200-hallway had not been functioning since he began working at the facility in . He recalled the AC contractor had previously assessed the unit and had ordered parts. Staff G further stated the contractor did not return to complete the repairs. He reported that the corporate maintenance director had been notified that the work was never completed on the AC condenser. He stated that, at the time of this survey, he was in communication with the facility's owner regarding this AC issue, and the owner indicated that he was . It. He added that the window AC units had been removed in , due to the cooler winter weather. On at approximately 11:34 AM, a telephone interview was conducted with one of the facility owners. The owner explained that the AC contractor had been at the facility to order parts; however, when the contractor did not return to complete the repairs, he acknowledged that he had lost track of the issue.	{A 152}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/17/2026
NAME OF PROVIDER OR SUPPLIER EMERALD GARDENS PROPERTIES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 N 72 AVENUE PENSACOLA, FL 32506		
(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 152}	Continued From page 3 On _____ at approximately 12:19 PM, an interview was conducted with Resident #4 on the 200-hallway. She stated that her room did not have air conditioning due to the building being older. She explained that she was a newer resident and had not resided in the facility during the summer months. On _____ at approximately 12:31 PM, an interview was conducted with Resident #3 on the 200-hallway. He explained that there was no air conditioning in his room and that at times his room became hot. He stated that he never had a window air conditioner installed and, when he felt hot, he opened the window. He added that he intended to purchase a fan in the future for his room. On _____ at approximately 12:45 PM, a combined interview was conducted with Staff D, _____ Assistant and Staff E, _____ Assistant. They explained that the _____ room was located on the 200-hallway. They confirmed the _____ room became hot at times and that there was no air conditioning present in the room. They stated that the facility provided a fan for them; however, the fan did not adequately address the heat during the summer months when temperatures became uncomfortable for the staff and the residents. They stated these elevated temperatures prompted them to provide _____ services outside of the _____ room to ensure a more suitable environment for the staff and the residents. On _____ at approximately 1:24 PM, an interview was conducted with the facility's Administrator. She explained that after the air conditioning system broke, she immediately	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/17/2026
NAME OF PROVIDER OR SUPPLIER EMERALD GARDENS PROPERTIES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 N 72 AVENUE PENSACOLA, FL 32506		
(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 152}	Continued From page 4 ordered window air conditioning units, which were installed in the resident's rooms. She stated that these units were removed in due to the cooler winter weather. She further explained that the previous AC contractor never returned to complete the repairs and the issue subsequently through the cracks. She agreed that the air conditioning issue was a concern and that it needed to be addressed as soon as possible. Class III	{A 152}		