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
	AL11969931	A. BUILDING: _____ B. WING _____	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEYS RESIDENTIAL HOME CARE	6205 VELDA DAIRY RD TALLAHASSEE, FL 32309

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A 000	Initial Comments An unannounced complaint survey for complaint #2026005365 was conducted on 4/14/26 through 4/15/26 at New Journeys Residential Home Care in Tallahassee, FL. A generator assessment was completed during this visit. Deficiencies were identified at the time of survey.	A 000		
A 010 SS=E	429.26(1-3) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) 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. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a stage 2 pressure sore may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.
(c) A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.
(g) Continued residency criteria for facilities

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to ensure residents met the criteria for continued residency for 3 of 6 residents reviewed. (Resident 1, 2 and 3) The findings include: 1. A record review was conducted for Resident #1, which revealed the resident was noted as bed bound, total care, and had diagnoses including Advanced dementia; Right Hip - unstageable wound, debrided on 3/27/26 and now at Stage 4 with admission to Hospice March 27, 2026. A review of the medication count and drug disposal form dated 4/8/26 revealed medications were disposed upon death of Resident #1. A review of the hospice transfer to the Funeral Home dated 4/8/26 verified that Resident #1 had passed. On 4/13/26 at 11:45 am, an interview with the Administrator confirmed that Resident #1 passed away on 4/8/26. She stated that the family wanted her at the facility on hospice. She received Home Health Services prior to being admitted to hospice. She stated Resident #1 started out as Day Stay only, but when her daughter had to travel/work and as the resident's health began to deteriorate, her daughter decided to admit her in January 2026. The resident was on palliative care at the time of admission. A review of Resident Health Assessment Form 1823 dated 3/1/23 for Resident #1 revealed the resident was independent for all Activities of Daily Living (ADLs) and needed assistance with Self	A 010		

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A 010	Continued From page 5 Administration of medications. A review of the Home Health Notes and notes from Hospice revealed the resident was visited regularly and they were providing wound care treatment to a Stage IV on the resident's hip. On 4/14/26 at 1:50 pm, an interview conducted with the Administrator revealed she did not have any specific notes/documentation to explain the exact admission date for Resident #1 to the facility. She stated the resident started out as day stay only, her daughter would bring her for the day while she worked, then she was at the facility on and off for a week or so for respite, periodically. She was not actually admitted to the facility until she was placed on palliative care on 3/27/26. At the time, the Administrator confirmed the resident had an unstageable/Stage IV wound and other multiple skin breakdowns. She was admitted to hospice on 4/7/26 and passed away on 4/8/26. When asked why there was not an updated 1823, and the Physician's statement stating her needs could be met at the facility, she stated when the Home Health diagnosis of the Stage IV Pressure Wound to her hip happened, the Home Health Agency advised the daughter they had 30 days to get her moved back home. However, she started declining so fast once she was placed on hospice, that she wound up passing one day later. She confirmed at this time, there was no updated Resident Health Assessment Form 1823. 2. On 4/13/26 at 11:20 am, an observation of Resident #3 revealed that she was sitting in a wheelchair in the common living area. When she was interviewed, she complained about the wheelchair hurting her hips. On 4/13/26 at approximately 1:00 pm, an	A 010		

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interview with the Administrator revealed Resident #3 is only at the facility for Respite Stay. She stated this is her second time staying at the facility while her daughter is out of town. She stated she normally lives with her daughter and this week she arrived on the evening of 3/31/26 and will return home 4/16/26.

The Resident Health Assessment Form 1823 dated 9/30/25 revealed that nursing/treatments/therapy service assistance requirements included administration of medications; peri care; incontinent of bowel and bladder. and "Total Care" for all activities of daily living except for eating. The physician checked "No" in response to the question "Can the individuals needs be met in an assisted living facility?"

3. On 4/13/26, the medical record for Resident #2 was reviewed. Resident #2 was admitted on 6/13/24 with diagnoses including dementia, heart disease, high blood pressure, and Type 2 Diabetes. The facility admitted Resident #2 to the hospital on 3/5/26 for treatment of a urinary tract infection and high sodium levels and returned to the facility on 3/13/26 under the care of hospice. Upon discharge from the hospital. Resident #2's Assessment for Assisted Living Facilities Form 1823 (Form 1823) dated 3/12/26 identified the resident's status as bedridden and requiring 24-hour nursing or psychiatric care and documented that the resident required total staff assistance with activities of daily living including bathing, grooming, toileting and transferring.

Hospice notes dated 3/14/26 documented that Resident #2 was bedbound and required dressing changes to wounds on her lower left leg, with education given to the caregiver for completing this task. Home Health Care staff performed the

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A 010	Continued From page 7 resident's dressing changes, and progress notes dated 3/24/26 stated that the resident was chairfast, unable to move, and required maximum assistance with position changes and is non-ambulatory. An interview was conducted with the Administrator on 4/13/26 at approximately 3:00 PM. She was asked why Resident #2 had not been moved to higher-level care given that the resident no longer qualified for residence in an assisted living setting. The Administrator stated that she did not notice that the documentation reflected this when the family returned the resident to the facility following hospital discharge. She stated that the assessment was inaccurate, Resident #2 was ambulatory with assistance and had never been bedbound requiring total care. On 4/14/26 at approximately 11:30 AM, the resident's Palliative Care Nurse Practitioner was interviewed. She was asked whether she had observed the resident's care and mobility needs. The Nurse Practitioner stated that she had made at least 3 visits to the facility for this resident and could not recall observing the resident walking. She observed that the resident was able to move her extremities and reposition herself. Class III	A 010		