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
	AL11965923	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACIOUS PLACE, LLC	1401 MAGNOLIA AVENUE SANFORD, FL 32771

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A 000	Initial Comments A complaint investigation (2026005640) was conducted at Gracious Place on and . Deficiencies were identified at the time of survey. Class I deficiencies were found at Tags A0025 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 a resident gained access to the unattended kitchen and ate food that resulted in a choking episode and subsequent . The facility's Administrator was notified of the Class I noncompliance on at 11:17 AM. The census at the start of the survey was 78. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the	A 025		

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A 025	Continued From page 2 resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision and a safe environment when 1 of 18 sampled residents (#1) gained access to and ate food that resulted in a choking episode and subsequent . Findings Included: Review of resident #1's record revealed a medical history of severe intellectual , since birth, , , , , and mental . The record showed the resident was nonverbal, diet was pureed, and she needed assistance with eating. The resident lived in the secure memory care unit of the facility. Review of camera footage revealed on at 11:54 AM, Caregiver A was seen sitting at a dining room table and Caregiver D was seen pouring drinks. They were the only two staff in the dining room. At 12 PM, Caregiver A left the dining room through a side door and Caregiver D left through the main door. Caregiver D did not close the door. At 12:02 PM, resident #1 entered the dining room through the open door then closed the door behind her. The resident immediately walked to the small kitchen area where she went behind a cabinet and could not be seen on camera. At 12:05 PM, the resident came into view	A 025		

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A 025	Continued From page 3 of the camera. The resident was then seen opening and closing the refrigerator door twice before falling to her right side. No further movement was seen from resident #1. At 12:10 PM, Caregiver D entered the dining room with a cart. Caregiver D continued setting up the tables. At 12:12 PM, Caregiver B entered the dining room then walked to the kitchen where she was seen looking down, then communicating something to Caregiver D. At 12:13 PM, Caregiver A re-entered the dining room through the side door then walked to the kitchen where she went behind the cabinet and was out of camera view. The footage was viewed with the Administrator on . he reported this was the first time he viewed the footage, five days after the incidentoccurred. On at 1:06 PM, Caregiver D state when she left the dining room on at 12 PM, she was confident that she locked the dining room door. She stated when she arrived with the food cart at 12:10 PM, she was certain she had to use her key to unlock the door. Caregiver D then said that after returning with the food she began placing utensils on the tables. She went on to say she did not see the resident lying on the kitchen floor. On at 10:48 AM, Caregiver B said that when she entered the dining room on at 12:12 PM, she walked to the kitchen and saw the resident lying on the floor. She said the resident's were closed and the resident did not respond when she called the resident's name aloud. She saw a piece of toast in the resident's and food particles around the resident's and on her cheeks. She said she removed the piece of toast from the resident's then turned the resident onto her side and then used	A 025		

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A 025	Continued From page 4	A 025		

her to , the resident's at which time spit came out of the resident's . She said Caregiver A arrived and began , ( ). Caregiver B said the resident was on a pureed diet because she had difficulty swallowing whole food. She explained the resident had to be fed and watched because she put things in her not consistent with a puree diet. She then said the dining room door was supposed to be locked when staff were not present, so residents did not go in.

On at 10:37 AM, Caregiver A said when she returned to the dining room on at 12:13 PM, Caregiver B told her the resident was on the floor. Caregiver A said she went to where the resident was then saw food particles around the resident's and on her cheeks. The caregiver said she called out the resident's name with no response from the resident. Caregiver A said she did not feel a , and did not see the resident breathing. She said she dialed 911, placed the call on speaker phone and then began until first responders arrived. She said the resident was transported to a hospital. Caregiver A said the dining room doors were to be locked when staff were not present to prevent residents from entering. The caregiver said the resident had to be watched because she would grab food off other residents' plates and put it in her . She stated the resident had to be fed because she ate too fast and also commented that the resident was on a puree diet because she did not chew the food. She reported knowing the resident was at risk of choking.

On at 1:25 PM, Caregiver C said the food eaten by the resident was food she placed on the kitchen counter. She said the food items were eggs, bread, chicken nuggets, and sausage.

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A 025	Continued From page 5 Caregiver C reported it was her personal food. On at 4:44 PM, the residents' health care provider stated she ordered a pureed diet because the resident would pocket food in her . Review of the medical examiner's report revealed the resident on at 12:58 PM. The report showed the cause of was asphyxia via airway occlusion by food bolus (inability to get enough due to a blockage of food stuck in the or airway). On at 3:53 PM, the Administrator said there was no written rule that the dining room had to be locked. He went on to say he did not know where the food came from that the resident ate. He said he did not interview Caregiver C and he was unaware, that it was her food that the resident ate. The Administrator said the resident was on a pureed diet because she put food in her fast and did not chew it before swallowing it. He said the resident had to be supervised during meals because she walked around and took food off other resident's plates. The Administrator reported the facility could not have prevented the incident. Class I	A 025		
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	A 077		

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A 077	Continued From page 6	A 077		

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.

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 ;
2. If employed on or after , 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

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A 077	Continued From page 7 408.809 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 , . , 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 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 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	A 077		

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A 077	Continued From page 8 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 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 maintain responsibility for the management of all staff and the provision of care to all residents when inadequate supervision and unsafe actions occurred for 1 of 18 sampled residents (#1.) Findings included:	A 077		

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A 077	Continued From page 9 Review of Resident #1's record revealed a medical history of severe intellectual since birth, , , , , and mental . The record showed the resident was nonverbal, diet was pureed, and she needed assistance with eating. The resident lived in the secure memory care unit of the facility. Review of camera footage revealed on at 11:54 AM, Caregiver A was seen sitting at a dining room table and Caregiver D was seen pouring drinks. They were the only two staff in the dining room. At 12 PM, Caregiver A left the dining room through a side door and Caregiver D left through the main door. Caregiver D did not close the door. At 12:02 PM, Resident #1 entered the dining room through the open main door then closed the door behind her. The resident immediately walked to the small kitchen area where she went behind a cabinet and could not be seen on camera. At 12:05 PM, the resident came into view of the camera. The resident was then seen opening and closing the refrigerator door twice before falling to her right side. No further movement was seen from resident #1. At 12:10 PM, Caregiver D entered the dining room with a cart. Caregiver D continued setting up the tables and did not see the resident on the kitchen floor. At 12:12 PM, Caregiver B entered the dining room then walked to the kitchen where she was seen looking down, then communicating something to Caregiver D. At 12:13 PM, Caregiver A re-entered the dining room through the side door then walked to the kitchen where she went behind the cabinet and was out of camera view. The footage was viewed with the Administrator on . He reported this was the first time he viewed the footage, 5 days after the incident occurred..	A 077		

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A 077	Continued From page 10 On at 1:06 PM, Caregiver D said when she left the dining room on at 12 PM, she was confident that she locked the dining room door. She stated that when she arrived with the food cart at 12:10 PM, she was certain she had to use her key to unlock the door. Caregiver D then said that after returning with the food she began placing utensils on the tables. She went on to say she did not see the resident lying on the kitchen floor. On at 12:12 PM, Caregiver B said that when she entered the dining room she walked to the kitchen and saw the resident lying on the floor. She said the resident's , were closed and the resident did not respond when she called the resident's name aloud. She saw a piece of toast in the resident's and food particles around the resident's and on her cheeks. She said she removed the piece of toast from the resident's then turned the resident onto her side and then used her to , the resident's at which time spit came out of the resident's . She said Caregiver A arrived and began , , ( ). She then said the dining room door was supposed to be locked when staff were not present, so residents did not go in. On at 10:37 AM, Caregiver A said that when she returned to the dining room on at 12:13 PM, Caregiver B told her the resident was on the floor. Caregiver A said she went to where the resident was then saw food particles around the resident's and on her cheeks. The caregiver said she called out the resident's name with no response from the resident. She said she did not feel a , and did not see the resident breathing. She said she dialed 911, placed the call on speaker phone, and began	A 077		

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A 077	Continued From page 11 until first responders arrived. She said the resident was transported to a hospital. The caregiver stated that the dining room doors were to be locked when staff were not present to prevent residents from entering. Review of the medical examiner's report revealed the resident on at 12:58 PM. The report showed the cause of was asphyxia via airway occlusion by food bolus (inability to get enough due to a blockage of food stuck in the or airway). On at 3:53 PM, the Administrator said there was no written rule that the dining room had to be locked. He reported the facility could not have prevented the incident. The Administrator said that following the incident he spoke with dietary staff and caregivers and discussed responding to a choking episode. The Administrator said he wanted to add a door and lock to the kitchen area but said he had to first check with the fire department to see if it was allowed. The administrator did not report he had made any attempts to contact the fire department or contractors about inserting another door to prevent a similar incident from occurring. The administrator failed to conduct a thorough investigation of the choking incident. There was no evidence of formal training for the staff related to residents who had been identified as at risk for choking, and no action had been taken post Resident #1's on to prevent a similar event from occurring. Class I	A 077		