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
	AL11968003	A. BUILDING: _____ B. WING _____	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALTERRA SENIOR LIVING AT MELBOURNE	964 S HARBOUR CITY BLVD MELBOURNE, FL 32901

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ZZ821 SS=D	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

AHCA Form 3020-0001

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

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821		

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ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident for 1 of 4 residents sampled. (#1) Findings:	ZZ821		

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ZZ821	Continued From page 4 On Tuesday resident #1 eloped from the secured memory care unit through an unlocked exit door with a ◡ alarm. A review of the preliminary Adverse Incident Report revealed it was submitted more than 1 business day of the incident on . Class III	ZZ821		
A 000	Initial Comments A complaint investigation #2026002682 and generator monitoring were conducted at Salterra Senior. Living at Melbourne. There were deficiencies identified at the time of the survey.	A 000		
A 025 SS=G	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 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	A 025		

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A 025	Continued From page 5 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 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 observations, interviews, and record reviews the facility failed to provide adequate	A 025		

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A 025	Continued From page 6 supervision and provide care and services appropriate to meet the needs of residents by failing to prevent elopement from a secure memory care unit for 1 of 3 residents sampled. (#1) Findings: On at approximately 5:50 PM, resident #1 eloped from the memory care unit through an unsecured door with a alarm. On at 10:45 AM, during a tour of the memory care unit, resident #1 was observed in her room. She was wearing an identification bracelet on her left . She was alert and talkative but unable to recall the elopement. A tour of the parking lot found there were 4 lane busy roads on the south and east sides. A review of resident #1's record revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated which identified resident #1 as an elopement risk on admission. Resident #1 was independent with ambulation and transferring. Her diagnoses included and . A review of resident #1's Service Plan dated found documentation that the community staff will be aware of residents' behavior. Provide routine wellness checks 1 x per shift. The resident will participate in activities. A review of a facility note dated at 5:46 PM, documented by caregiver A - Resident # 1, was observed on the west side of the building. Brought in and an evaluation was completed. Family and Primary Care Provider	A 025		

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A 025	Continued From page 7 made aware. 15-minute checks initiated. On at 12:20 PM, during an interview with the Administrator she confirmed resident #1 was able to leave through the memory care exit door because the door did not lock after being open for an extended period when dietary was bringing in meal carts. The unlocked door allowed the resident to exit freely. The Administrator went on to say the door did not alarm because the alarm was . She also added, the open door should have sent an alert to the caregivers' walkie talkies but, that also was . The memory care door opens to the main building. The Administrator stated she reviewed the camera footage that showed resident #1 walking out of the memory care door, past the business office, past the , , room, through the common area, past the Wellness Directors office, past the Administrators office, and past the receptionist. The Administrator added, the receptionist was busy assisting someone else. The Managers had all left for the day. Resident #1 then exited through the South lobby door leading to the parking lot. The Administrator said the door alarm company had fixed this issue and the exit door locks immediately when the door is closed, the alarm continuously sounds when the door is opened without a key card, and an alert is sent to the walkie talkies. On at 1:25 PM, an interview with caregiver A was conducted. She stated on around 6 PM the receptionist called to inform her that a family member saw resident #1 in the parking lot west of the main building. She said she immediately went outside and escorted resident #1 inside. She evaluated the resident and found no injuries.	A 025		

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A 025	Continued From page 8 A review of a log provided by the Administrator revealed the memory care exit door was unlocked for 13 minutes. The lock was disengaged at 5:49 PM and reengaged at 6:02 PM. On at 2:40 PM, the Administrator confirmed the findings. Class II	A 025		

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ZZ821	Continued From page 4 On Tuesday resident #1 eloped from the secured memory care unit through an unlocked exit door with a ◡ alarm. A review of the preliminary Adverse Incident Report revealed it was submitted more than 1 business day of the incident on . Class III	ZZ821		
A 000	Initial Comments A complaint investigation #2026002682 and generator monitoring were conducted at Salterra Senior. Living at Melbourne. There were deficiencies identified at the time of the survey.	A 000		
A 025 SS=G	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 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	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968003	A. BUILDING: _____ B. WING _____	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALTERRA SENIOR LIVING AT MELBOURNE	964 S HARBOUR CITY BLVD MELBOURNE, FL 32901

(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 025	Continued From page 5 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 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 observations, interviews, and record reviews the facility failed to provide adequate	A 025		

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A 025	Continued From page 6 supervision and provide care and services appropriate to meet the needs of residents by failing to prevent elopement from a secure memory care unit for 1 of 3 residents sampled. (#1) Findings: On at approximately 5:50 PM, resident #1 eloped from the memory care unit through an unsecured door with a alarm. On at 10:45 AM, during a tour of the memory care unit, resident #1 was observed in her room. She was wearing an identification bracelet on her left . She was alert and talkative but unable to recall the elopement. A tour of the parking lot found there were 4 lane busy roads on the south and east sides. A review of resident #1's record revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated which identified resident #1 as an elopement risk on admission. Resident #1 was independent with ambulation and transferring. Her diagnoses included and . A review of resident #1's Service Plan dated found documentation that the community staff will be aware of residents' behavior. Provide routine wellness checks 1 x per shift. The resident will participate in activities. A review of a facility note dated at 5:46 PM, documented by caregiver A - Resident # 1, was observed on the west side of the building. Brought in and an evaluation was completed. Family and Primary Care Provider	A 025		

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A 025	Continued From page 7 made aware. 15-minute checks initiated. On at 12:20 PM, during an interview with the Administrator she confirmed resident #1 was able to leave through the memory care exit door because the door did not lock after being open for an extended period when dietary was bringing in meal carts. The unlocked door allowed the resident to exit freely. The Administrator went on to say the door did not alarm because the alarm was . She also added, the open door should have sent an alert to the caregivers' walkie talkies but, that also was . The memory care door opens to the main building. The Administrator stated she reviewed the camera footage that showed resident #1 walking out of the memory care door, past the business office, past the , , room, through the common area, past the Wellness Directors office, past the Administrators office, and past the receptionist. The Administrator added, the receptionist was busy assisting someone else. The Managers had all left for the day. Resident #1 then exited through the South lobby door leading to the parking lot. The Administrator said the door alarm company had fixed this issue and the exit door locks immediately when the door is closed, the alarm continuously sounds when the door is opened without a key card, and an alert is sent to the walkie talkies. On at 1:25 PM, an interview with caregiver A was conducted. She stated on around 6 PM the receptionist called to inform her that a family member saw resident #1 in the parking lot west of the main building. She said she immediately went outside and escorted resident #1 inside. She evaluated the resident and found no injuries.	A 025		

Agency for Health Care Administration

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A 025	Continued From page 8 A review of a log provided by the Administrator revealed the memory care exit door was unlocked for 13 minutes. The lock was disengaged at 5:49 PM and reengaged at 6:02 PM. On at 2:40 PM, the Administrator confirmed the findings. Class II	A 025		