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
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 000	Initial Comments An unannounced Complaint Investigation, complaint numbers 2026004990, 2025016527, 2026004063, 2026001619, 2026005355, was conducted at Northlake Living on - . The facility had deficiencies related to Complaints 2026004990, and 2026005355, at the time of the survey.	A 000		
A 025	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 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,	A 025		

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
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 1 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 observation and interview, the facility failed to provide supervision to ensure the ongoing observation of residents; maintaining a general awareness of the health, safety, and physical and emotional well-being of residents for fourteen (14) of twenty-two (22) Residents sampled/or reviewed (1,2,4,7,8,9,10,11,12,13,15,16,21,22). The Findings Include: a). In an interview with the Administrator on at 12:53 PM this surveyor made a	A 025		

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
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 2	A 025		

request for the facility's Supervision Policy. She stated they don't have a policy, but they have a Care Log that they just started using. The Administrator provided this surveyor with the binder containing template documents. This surveyor asked if they had any logs for last month ( ) and she stated they (staff) are just getting used to it, so they just started using it. A review of the Binder revealed CNA Daily Care Log sheets divided by shifts that is intended to capture when the staff member checked on the resident. It also contained A Daily Assignment log, and ALF Resident Refusal Agreement intended to document when a resident refuses assistance with their ADLS (copies obtained).

A review of the North Lake Incident Report dated provided to this surveyor by the Administrator documented the Patient says he was trying to transfer himself from the bed to his wheelchair. Loss his balance and . was seen lying on the right side says he was lying on the floor for an hour. Bed rail was under bed (copy obtained).

A review of Resident #6's Health Assessment, AHCA Form 1823 (1823) dated documented his diagnosis as , , , Unspecified Psychoses. It also documented his Assistance with Daily Living (ADLS) as Independent in Ambulation, , Eating, Grooming, Toileting, Transfer. And Supervision in bathing.

A review of Resident 6's facility file and documents revealed a "Documentation For Communication Of Client's Care" which documented the following entries:

- - Staff reported , @ 3:30 in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 3	A 025		

bathroom of T.V. room. trying to go to the toilet and . No injuries noted. move all extremities. helped to wheelchair by staff taken to dining table for dinner. PCP/Family notified.

- - Night Staff reported , out of bed. No injuries noted. denies /discomfort. PCP/Family notified.

- - Nurse reported , cousin (name) report to her that , and , told him he has been on the floor about an hour. Upon entering , room , was on the right side with coming from the left upper temple area. 911 was called and , taken to hospital. (Name of) Hospice notified (copy obtained).

In an interview with Resident #15 (one of Resident #6's roommates) on at 10:31 AM he stated he had gone out to the dining area (around 6:00ish AM) and when he came to the room, he saw staff and the paramedics around Resident #6, with all over. He stated Resident #6 was taken to the hospital and he . (Observation of the room revealed the bed that Resident #6 slept in had been removed. And that Resident #15's bed is positioned adjacent to his and had a straight line-of-site to Resident #6's bed.

In a confidential interview on at 11:00 AM the complainant stated he/she worked at the facility for over years, and after the change in ownerships things started going down. He/she stated after the facility was sold, family members started calling him/her with compliants. He/she stated they left employment at the facility because they could not take it. He/she stated employees and residents still call him/her complaining that there are no activities, there is a lack of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 4	A 025		

administration, and the Administrator is firing people left/right; and there is no supervision at all. He/she stated the Resident care and supervision has gone down tremendously. Relative to Resident #6, he/she stated that the Resident #6 got out of bed everyday at 6:00 AM religiously. And that if he has to go to the bathroom, he would get ups and go because he did things for himself. He/she stated this was known to the facility staff and someone should have checked on him because they knew his routine and that he needed assistance, but none was being provided with his showers, or anything.

In an interview with a family member of Resident #6 on at 2:41 PM, he stated things have really gone down in the last month. He stated Resident #6 could not walk and was in a wheelchair. He stated Residents of the facility would tell him that they don't bathe Resident #6. And sometimes Resident #6 would not eat because they didn't take him to the dining room or bring him his food. He stated that on the day of the incident ( ) he stated he came to the facility about 8:30 AM and Resident #6 was not in the breakfast room, so he went to his room and found him on the floor. He stated he asked Resident #6 how long he had been on the floor and he said about an hour and 30 minutes. He stated if they (facility staff) would check to see if a person (Resident) isn't at breakfast they would know to go check on them. He stated that if they did that, Resident , be alive today.

b). A review of six Resident facility files by this surveyor documented five (5) of the six (6) residents reviewed had a mental health diagnosis (Resident #1, 3, 6 (no longer at facility), 21), thus indicating the facility accepts/or currently have residents with mental health diagnosis as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 substantiated during a previous interview with the facility's Independent , provider on at 12:06 PM. She stated during the interview that the primary diagnosis she has seen exhibited thus far are , , Aggressive language, No , , , , . As documented by the healthcare professional, and observations by this surveyor, the facility has residents with mental health diagnosis which may require frequent observation, monitoring, redirecting or supervision. Observation and interviews by this surveyor on and revealed the following: During the survey observations by this surveyor on both days revealed residents in walkers/or wheelchairs propelling themselves through tight spaces, attempting to enter the restroom located in the South-end of the North Activity/TV/Dining room without the assistance of staff as they were not in the area. Observation of the Activity/TV/Dining room area also revealed residents laboring to move, sitting in chairs at tables, or locked in Gerry chairs generally unattended throughout the day. On at 10:55 AM observation was made of Resident #8 pushing Resident #2 out of the TV/Dining room area and into the courtyard/patio in her wheelchair. There were no staff present to assist with the Resident so he assisted. During an interview with Resident #7 on at 10:51 AM she was observed by this surveyor wearing a soiled shirt and pants, and a yellow hospital bracelet around her left arm.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 6 On at 1:13 PM observation was made by this surveyor of a male Resident in his wheelchair struggling to enter the TV/Dining room section of the facility from the outside courtyard area. No staff were present to assist him. This surveyor attempted to conduct an interview with him, but he was only able to mutter sounds. On at 11:18 AM this surveyor made observation of Resident #7 still at the table where he was observed at 10:28 AM in a soiled gray sweatshirt with his down. Observation also revealed 25-30 residents in the TV/Dining room area sitting with the mounted TV on the North wall playing videos. No staff was observed to have come to the area to provide observation and supervision of the residents. On at 1:17 PM observation was made of Resident #21 who was sitting in her Gerry chair located against the East Wall of the North Dining/TV room with the tray in a locked position so that she could not get out. There were three other residents in Gerry chairs on either side of her with their trays locked in position as well. This surveyor observed the same residents in the same position on at 9:56 AM with no activities taking place, and no staff present to observe and assist them. In an interview with Resident #1 on at 11:08 AM she stated she needs more help with her ADLS (Activities of Daily Living) but stated it would cost more money. She stated she needs help with changing her bed and with her showers (the resident was observed by this surveyor using a walker for assistance with walking). She stated she needs help with showers more than every 3 weeks. She stated the female staff that work at the facility is overworked and don't have time to	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 7 help the residents because they are understaffed. She stated no one checks on them at night because she is a light sleeper and would know if someone came into the room. In an interview with the Administrator on at 5:16 PM she was informed of the findings related to supervision of residents. She restated the new procedures they have implemented and referenced the binder provided earlier. Further review of the Binder revealed template documents of CNA (Certified Nursing Assistants) Daily Care Log sheets divided by shifts that is intended to capture when the staff member checked on the residents. It also contained A Daily Assignment log, and ALF Resident Refusal Agreement that is intended to document when resident refuses assistance with their ADLS (copies obtained). However, no complete documents were provided. Nor were any specific documents outlining staff supervision/monitoring requirements for residents presented. No additional information was provided during the survey. Class III	A 025		
A 026	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 026	Continued From page 8 selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide residents with Scheduled activities at least 6 days a week for a total of not less than 12 hours per week. And those specifically designed for persons who are The Findings Include: During the survey conducted at the facility by the survey team on and this	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 026	Continued From page 9	A 026		

surveyor observed that there were no activities being conducted on either day. Observation revealed between 15-20 residents in the dining/activity/Television (TV) room located in the North section of the facility, sitting at a table, lying in Gerry Chairs, or watching TV throughout the time of the survey.

Additionally, during the above observation this surveyor observed residents who were sitting in the smoking area of the courtyard located just outside the door by the Nurse's/Medication room which leads to the outside. Resident #8 stated there are no activities for them, so people just come out here.

In an interview with Resident #8 on at 10:55 AM he stated he has been at the facility for about 3 months, the breakfast was good, he get snacks, he stated the staff is good, they clean his room, he has no concerns. He stated he wishes there was something to do but there isn't. He also stated that he can do things for himself so he help other residents out (This surveyor observed him pushing a Resident out of the TV/Dining room, onto the courtyard patio in her wheelchair).

In an interview with Resident #9 on at 11:04 AM she stated she has been in the facility for a long time, the food could be better, she gets her medications but not sure what, and there is absolutely no activities or anything to do.
In an interview with Resident #1 on at 11:08 AM she stated there is nothing to do at the facility. There are no activities, so residents get into fights or just sit around doing nothing.

In an interview with Resident #10 on at 11:29 AM he stated he has been in the facility for years, they are short-staffed since about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 026	Continued From page 10 , of this year, the food is so-so, he gets his medications on time, but there is nothing to do and he would like to see the facility provide some activities. In an interview with Resident #11 on at 11:34 PM he stated his medications are a mess (gets them/sometimes they are missing). He also stated that there are no activities and they (Residents) have nothing to do all day. In an interview with Resident #13 on at 11:4 AM she stated the food could be better; the facility could provide some activities as there are none presently. In an interview with Resident #14 on at 12:09 PM she stated she has been in the facility for 1 year, she gets her medications, the food is okay, the staff is good and they check on her. She stated there are no activities and that she stays in her room reading. In an interview with Resident #15 on at 10:31 AM he stated he is doing okay, gets his medications, the food is okay. He stated he goes out in the mornings to the courtyard as there is nothing to do, no activities. In an interview with Resident #11 on at 10:40 AM she stated there are no activities provided, so residents sit around with nothing to do. In an interview with the Administrator on at 5:53 PM she stated they have activities that come in the afternoon and one that come in the morning from a Behavioral Health Program. However, during the two-day survey this surveyor did not observe any activities being	A 026		

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
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 026	Continued From page 11 provided. Class III	A 026		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 052	Continued From page 12 assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 052	Continued From page 13 medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 052	Continued From page 14 prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medications are administered to residents in a safe/confidential manner. And ensure that medications given to Residents are ingested as prescribed. The findings Include: On between 12:21 PM and 12:25 PM	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 052	Continued From page 15 this surveyor observed Staff F MedTech gather medication from the med cart, place them on top of the med-cart, and cut the plastic packaging with scissors one at a time for five (5) Residents. After opening the packages, took them one at a time to the Residents as they sat at the table in the dining room eating lunch, poured the medication in their without announcing what they were, and walked away without watching them swallow. This surveyor also observed that Staff F did not ask any of the residents their names or announce the medication that was being given to ensure that medications were given to the person to whom it was prescribed. As it was unknown to this surveyor how many residents were assisted before his arrival into the dining room where she was conducting the passes, this surveyor requested the empty packets to determine what was given and to whom it was given to. The packets were provided to the surveyor. However, they had been cut, mixed and discarded in a way that would not allow the proper identification of the resident names/or medication. In an interview with Resident #11 on at 11:34 PM stated his medications are a mess (gets them/sometimes they are missing). And that they don't tell him what he is getting. In an interview with Resident #12 on at 11:42 AM that she is doing good, been in the facility 1 year, she gets her medications but don't know what she is getting (don't tell her). In an interview with the Administrator on at 5:53 PM she was informed of Staff F's Med-Pass observation by this surveyor. She	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 052	Continued From page 16 stated she is still new (employee at the facility) but will address the findings with her. No additional information was provided during the survey. Class III	A 052		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 055	Continued From page 17 other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 055	Continued From page 18 prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to develop/or implement practices/procedures to ensure medications delivered to the facility were safeguarded from theft/or loss, and available for administration to Residents as ordered/or prescribed by their healthcare provider for one (1) of seven (7) Residents sampled (Resident #1). The Findings Include: A review of an Incident Report dated , , and provided to this surveyor by the Administrator on documented that Staff H, MedTech stated Staff E received and signed for medication ((IR) 15mg -1 tablet by 4xday) for Resident #1 and placed it on her desk. Staff H stated in the document that she reported that Staff E later placed the medication into the medication cart and secured it. Staff H also indicated that she	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 055	Continued From page 19	A 055		

instructed the medication aide (Staff E) to place the medication in her white pouch under her desk after use. Staff H further stated that on , , that she intended to verify the medication but did not complete a count at that time (copy obtained).

A review of the Resident's 1823 dated documented her diagnosis includes: , (,), , , , , , , Occlusion and of (right) Carotid , Myopathy, ( ), B/P ( ), , (Post Stress), , , , (,), , ( ), , , , ( ), . Review of the Resident's 1823 also documented her Activities of Daily Living (ADLS) as Assistance: Ambulation, Bathing and Supervision with , Eating, Grooming, Toileting, Transfer (copy obtained).

A review of the Resident #1's Medication Observation Record (MOR) by this surveyor on revealed the Resident was not given her ordered and prescribed by her healthcare professional from - as it went missing after it was delivered to the facility on . The prescribed medication (,) was re-delivered and administered on .

In an interview with the Resident #1 on at 11:08 AM she stated she is on , meds which the facility lost last week. Specifically, she stated her was delivered to the facility and then stolen, and the facility didn't tell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 055	Continued From page 20	A 055		

her or her doctor anything. She stated she called the pharmacy and was told that 2 ½ weeks of the medication was missing, and the facility informed them (pharmacy) that a previous employee stole them. She stated she takes the medication 4 times a day and was in severe , for the days when she was without it. And that because of her not having the , her went above . She stated the facility knew they were missing for five days prior to them being replaced, and they did nothing to prevent it. She further stated that stays in a lot of , due to the she incurred in her , . She stated that when she misses her medication it causes her , to go up above which is not good.

In an interview with Staff B, on at 3:38 PM she stated the medication (,) for Resident #1 was delivered by the pharmacy and signed off by Staff H, MedTech and was left on the desk (inside the nurse's office) which she saw. She stated she found out days later it was Resident #1s medication that was left on the desk. She stated Staff H was here that day/signed for the medication, and that the medication has not been found to date. No additional information related to the missing medication was provided.

In an interview with Staff E, MedTech on at 5:08 PM he stated he received the medication (,) around 10:30 PM (on) and signed for the , that was delivered for Resident #1. He stated that when he received the medication, he put them on the table located in the Nurse's/Medication room so that the 3:00 PM - 11:00 PM shift would see them. He stated the door to the room is locked, so he doesn't know what happened to them. No

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
	AL11910716	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE LIVING	1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020

(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 055	Continued From page 21 additional information was provided. In an interview with the Administrator on at 3:42 PM that Staff H told her via telephone on /202 at 9:47 PM that the medication was delivered and she signed for it. And that she left it on the desk and did not know what had happened to them. As a result of the , medication (,) going missing, Resident #1 did not receive the medication from - , which she is said to take 4 times daily for severe , . No additional information was provided related to the missing medication during the survey. Class II	A 055		