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
	AL11942716	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER OF WINTER PARK	558 N. SEMORAN BLVD. WINTER PARK, FL. 32792

(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 SS=D	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 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;	A 055		

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A 055	Continued From page 1 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 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	A 055		

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A 055	Continued From page 2 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 observation, interviews, and record reviews, the facility failed to centrally store medications for 2 of 13 sampled residents (#8, #12) who received assistance with medications. Findings: On at 9:40 AM, a bottle of over-the-counter men's was seen on a table in the room shared by Residents #7 and #8. On at 8:20 AM, the bottle of was seen on the same table in the resident's room. Resident #8's record showed the resident needed assistance with medications. The record had no documentation to show the resident could store the in his room. On at 12:50 PM, the Wellness Director said the was not supposed to be stored in the resident's room. Review of Resident #12's health assessment (1823) dated revealed, resident required assistance with self-administration of medication.	A 055		

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A 055	Continued From page 3 On at 10:02 AM, observed a bottle of Extra Strength 500 MG in the Resident room on a table near his chair. Resident was unable to verbalize how he obtained the . During an interview on at 10:06 AM, the findings were discussed with Unlicensed Caregiver D, who said she did not know the resident had in his room. The caregiver added that the resident is prescribed and is being given during medication pass. The Caregiver said she will need to speak with the Wellness Director to verify if the resident should have the in his room. During an interview on at 12:46 PM, the findings were discussed with the Administrator, who said he did not know if the resident had an order to self-administer his medication and keep it in his room. During an interview on at 2:43 PM, the findings were discussed with the Wellness Director, (WD). The WD confirmed the findings and said the resident does not have an order for bedside for him to self-administer by himself. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. (photographic evidence obtained) Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders	A 056		

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A 056	Continued From page 4 (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by	A 056		

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A 056	Continued From page 5 the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S.,	A 056		

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A 056	Continued From page 6 before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to make every reasonable effort to ensure that medications were refilled in a timely manner for 6 of 13 sampled residents (#1, #8, #10, #17, #18, #19) and failed to obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record for 1 of 13 sampled residents (#13). Findings: 1. 10:15 AM, resident #1 said some of her medications ran out, including , , , and others she could not name. The resident said she was not given a reason why. Resident #1's record showed the resident needed assistance with self-administration of medications. The residents' , medication observation record (MOR) showed , , , , fish oil, , , , and , ran out. There was no documentation to show the facility made efforts to obtain refills prior to the medications running out. On at 12:50 PM, the findings were discussed with the Wellness Director.	A 056		

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A 056	Continued From page 7 On at 3:15 PM, the Wellness Director said there was no additional documentation for the findings. 2. Resident #8's record showed the resident needed assistance with self-administration of medications. The residents' and MORs showed , , , ran out. There was no documentation to show the facility made efforts to obtain a refill prior to the medication running out. On at 10:35 AM, the Wellness Director confirmed the findings. 3. Review of Resident #10's 1823 health assessment indicated he needs assistance with self-administration of medications. Review of his , MORs from the 8th - 29th revealed code 9 = other/see progress notes for , Tablet, give 1 tablet every morning and at bedtime for . On at 10:20 AM, Resident #10 was observed in his room asleep and unable to interview regarding the missed doses of his medication. On at 10:28 AM, Unlicensed Caregiver A stated the resident is out of his medication. She said he has a co-pay and he doesn't have it. She stated she had contacted the pharmacy directly and that is what she was told why the medication has not been delivered. She stated other times she's left a piece of paper on the nurse's desk to make aware the resident is out of his meds. On at 10:34 AM, Unlicensed Caregiver F stated she has given the resident his medication in the past. Adding, he is out of his , ,	A 056		

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A 056	Continued From page 8 and the pharmacy is not sending it because he has a co-pay. The Medication - Labeling and Orders Policy dated states the facility will make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. On at 11:03 AM, the Wellness Director stated she will reach out to the pharmacy to get copies of sending the request when asked about Resident #10's refills. She stated she also reached out to his psych doctor about not having his meds. The Wellness Director was asked why the facility did not order the medication if their policy states it will make every reasonable effort to ensure that prescriptions are filled or refilled in a timely manner. She stated, "she cannot force the Administrator to pay the co-pay as he will not pay for it." On at 11:12 AM, the POA stated there was one medication that they could not afford and she made the facility aware. She said someone from the facility called her and she made them aware at that time she could not afford the co-pay. Adding, she does not recall the name and unsure who called her. She said they told her they would reach out to the doctor to see if they could find a cheaper alternative. She said she was unaware the resident had been without his med all this time. On at 11:18 AM, Resident #10's ARNP stated no one from the facility made her aware the resident had not taken his medication since , . Adding, yes, she's aware that families are	A 056		

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A 056	Continued From page 9 unable to cover the co-pay at times for some medications. When that happens, she will find alternative medication. Adding, the resident should not have gone that long without his , as it's for his and will find something else for him to take. On at 12:35 PM, the Administrator stated he was not aware the resident was out of his medication since , . Adding, no one mentioned anything to him about a co-pay issue and that if he had known it would have been paid for. On at 1:20 PM, the Administrator stated he spoke with one of the ARNP's visiting the facility today and stated she will see Resident #10 to determine if he still needs the , . Further stating, he has also reached out to the pharmacy to make them aware if the resident needs the medication to refill immediately and send to the facility. 4. Review of Resident #13's record revealed an admission date of , 1823 indicated he needed assistance with medication self-administration. Observations made on at 10:51 AM, revealed Unlicensed Caregiver A gave Resident #13 Sevelamer 800 milligrams (mg) 4 tablets. Review of the MOR revealed directions for use was 4 tablets by with meals. Review of the prescription label revealed directions for use were 2 tablets by three times a day with meals and 1 tablet by twice a day with snacks. When asked about it, the caregiver said she does not follow the medication label she follows the MOR and a nurse was responsible for putting an	A 056		

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A 056	Continued From page 10 alert label on the medication package. Review of Resident #13's record revealed that on a Health Care Provider ordered the medication to be given three times a day, 4 tablets. During an interview on at 2:45 PM, the findings were discussed with the Wellness Director (WD), who said the staff were to put on an alter label on the medication packaging when the directions change. Review of the facility's medication labeling and orders policy dated , indicated an alert sticker will be affixed to the medication container, or a revised label will be obtained from the pharmacy. 5. Review of Resident #19's record revealed a Health Assessment form 1823 dated . The resident has a diagnosis of and requires assistance with medication self-administration. Review of the , MOR revealed there is a 9- see other notes for , 10 mg and - oral tablet. During an interview on at 9:39 AM, the findings were discussed with the WD, who said 9 meant the medication is not available. The WD added that the family does not want to provide . The WD said she does not have documentation of the encounter with the family. There was no documentation in the record to indicate the facility requested the medications in a timely manner.	A 056		

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A 056	Continued From page 11 During an interview on at 11:41 AM, the findings were discussed with Unlicensed Caregiver A. The Caregiver said she reached out to the pharmacy last night and they informed medication will be sent out today. The caregiver does not recall when the medication ran out. During an interview on at 9:39 AM, the WD said the family does not want to order the and there was no documentation done when the staff reached out to the family and the health care provider. During an interview on /6 at 11:57 AM, the WD said the was not ordered days before the medication ran out. Review of the facility's medication labeling and orders policy dated , indicated the facility will make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. 6. Review for Resident #17 record revealed date of admission . The last 1823 health assessment dated listed medical history of type 2, following , and major . He needs assistance with self-administration of medications. In further review for and showed on the Medication Observation Record (MORs) medications were not available (marked "9") listed below: , 25mg-meds not available	A 056		

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A 056	Continued From page 12 40mg-meds not available 400mg-meds not available 25mg-meds not available 5mg-meds not available 81mg-meds not available D3 125mcg-meds not available 400mg-meds not available 1000mg-meds not available On at 11:03 AM, an interview with Resident #17 said that his medications were not available a few times because he told the Wellness Director that he no longer need these medications. On at 11:20 AM, an interview with the Wellness Director stated that she was not aware of this conversation. 7. Review of Resident #18's record revealed date of admission . The 1823 health assessment dated listed medical history of acute and failure with ; obese due to excess calories; essential ; type 2 with , dry , sleep ,	A 056		

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A 056	Continued From page 13 ( ) with acute exacerbation, and dependency. Furthermore, the 1823 health assessment documented that he could administer his own medications. On at 9:32 AM, an interview with the Wellness Director said that Resident #18 asked the facility to assist with self-administration of medications and confirmed that she did not get a new order for direction for medication assistance. A review of the , MORs "marked 9" meaning medications were not available below: 2mg-meds not available 6.25mg-meds not available 30mg-meds not available 300mg-meds not available One Day / -meds not available 40mg-meds not available Polyvinyl solution 1.4%-meds not available 25mg-meds not available 8.6mg-meds not available 25mg-meds not available 50mg-meds not available B1 100mg-meds not available 500mg-meds not available On at 11:39 AM, an interview with the Wellness Director confirmed the "9s" marked on the MORs meant that medications were not available and confirmed the findings. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings.	A 056		

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A 056	Continued From page 14 (Photographic Evidence Obtained) Class III	A 056		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during	A 081		

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A 081	Continued From page 15 inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its	A 081		

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A 081	Continued From page 16 control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training	A 081		

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A 081	Continued From page 17 regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure that 3 of 4 sampled staff (A, B, C) completed in-service training required within 30 days of employment. Findings: 1. Review of Caregiver C's personnel record revealed hire date . There was no documentation that the required facility specific in-service training was not completed based on the facility's policies and procedures for the following: a) 1-hour control training b) 1-hour emergency procedures and evacuation training c) 1-hour , neglect and , training d) and an elopement response training On at 3:35 PM, an interview with the Business Office Manager confirmed the findings.	A 081		

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A 081	Continued From page 18 2. Review of Caregiver B's personnel record revealed a hire date of . The record did not have documentation to show the caregiver completed a 1-hour training on the facility's control policies and procedures. On at 4:45 PM, the Business Office Manager confirmed the findings. 3. Review of Caregiver A's personnel record revealed a hire date of . A 2-hour preservice orientation certificate of training was not signed by both the caregiver and the Administrator, as required. Further review on the record revealed internet-based training certificates for control and major emergency and evacuation dated , elopement and , dated , and , neglect, and , dated . The record did not contain documentation to indicate the caregiver received training on the facility's policy and procedures for either of the training courses. During an interview on at 4:24 PM, the BOM gave copies of the internet-based certificates. There was no documentation to indicate the training courses were on the facility policies. The findings were discussed with the BOM. During an interview on at 4:43 PM, the findings were discussed with the Administrator. On at 5 PM, no additional documentation was provided.	A 081		

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A 081	Continued From page 19 On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. (photographic evidence obtained) Class III	A 081		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and	A 084		

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A 084	Continued From page 20	A 084		

ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.
(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:
1. Read and understand a prescription label;
2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:
a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms;
b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
c. Recognize the need to obtain clarification of an "as needed" prescription order;
d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;
e. Complete a medication observation record;
f. Retrieve and store medication;
g. Recognize the general signs of adverse reactions to medications and report such reactions;
h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;
i. Assist with ;
j. Use a to perform

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A 084	Continued From page 21 testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed	A 084		

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A 084	Continued From page 22 pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure that 1 of 5 sampled staff (H) completed 6 hours initial training when providing assistance with self-administration of medications to residents in an assisted living facility required. Findings: Review of Unlicensed Caregiver H's record revealed hire date . There was no documented evidence that 6 hours of medication assistance and management training was not completed with understanding and reading the medication prescription labels, assisting with correct dosage and route and completing the Medication Observation Record (MORs) each time medication was passed to residents. Review, the staff work schedule verified that Unlicensed Caregiver H works the 3rd shift (10:45 PM-7:15 AM) assisting residents with self-administration of medications overnight hours and a review of MORs for residents #17 and #18 documented that Unlicensed Caregiver H signed off on the MORs in and , . On at 3:45 PM, an interview with the Business Office Manager confirmed the finding and further said that she thought Unlicensed Caregiver H had completed at least the 2 hours annual medication update training and did not have the documentation.	A 084		

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A 084	Continued From page 23 On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. (photographic evidence obtained) Class III	A 084		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 2 of 5 sampled staff (A and C) received at least one hour of training in the facility's policy and procedures regarding ( ) within 30 days after employment. 1.Review of Caregiver A's personnel record revealed a hire date of .	A 090		

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A 090	Continued From page 24 The record contained a internet-based training certificate. The record did not include documentation to indicate the caregiver received at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. During an interview on at 3:17 PM, the findings were discussed with the Business Office Manager (BOM). During an interview on at 4:24 PM, the BOM provided another copy of the internet-based training, and the findings were discussed with the BOM. During an interview on at 4:43 PM, the findings were discussed with the Administrator. On at 5 PM, no additional documentation was provided. 2. Review of Caregiver C's personnel record revealed hire date . There was no documented evidence that 1-hour of ( ) training was not completed as required to the specifics of the facility's policies and procedures. On at 3:35 PM, an interview with the Business Office Manager confirmed the findings. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. Class III	A 090		

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A 093	Continued From page 25	A 093		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of	A 093		

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A 093	Continued From page 26 the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.	A 093		

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A 093	Continued From page 27 Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have documentation to show its menus were reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist. Findings: Review of the facility's menus revealed the review was not dated.	A 093		

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A 093	Continued From page 28 On at 12:40 PM, the Dietary Manager confirmed the findings. Class III	A 093		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018,	A 160		

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	AL11942716	A. BUILDING: _____ B. WING _____	04/30/2026

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A 160	Continued From page 29 F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years.	A 160		

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A 160	Continued From page 30 (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on facility record reviews and interview, the facility failed to maintain a satisfactory fire inspection. Findings: Review of the facility's Orange County Fire and Rescue Department Inspection Notice dated indicated fail, floor 1 fire protection system, repair or replace defective fire protection	A 160		

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A 160	Continued From page 31 system. Action required: location shall contact the fire sprinkler system contractor, make required repairs on their system and will return to replace painted sprinkler heads in units 500 and 501. On at 11:55 AM, the Administrator, after reviewing the inspection report stated the sprinklers in & 501, with the partial red tag need to have the sprinkler heads replaced. On at 3:35 PM, the Maintenance Director stated the sprinkler company, who was already scheduled to arrive this morning to make the changes based on the inspection report to repair the two (2) heads in & 501. Further stated he sent the completed report to the Fire Marshall. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. (photographic evidence obtained) Class III	A 160		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of	AN277		

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AN277	Continued From page 32 such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to employ or contract with a registered nurse to conduct monthly assessments. Findings: The facility's license showed the facility was licensed to provide limited nursing services. On at 1:10 PM, the Administrator said the facility did not employ or contract with a registered nurse because no residents received a limited nursing service. Class III	AN277		

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ZZ821	Continued From page 33	ZZ821		
ZZ821	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:	ZZ821		

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ZZ821	Continued From page 34 https://apps.ahca.myflorida.com/SingleSignOnPortal. 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,	ZZ821		

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ZZ821	Continued From page 35 AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available 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.	ZZ821		

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ZZ821	Continued From page 36 7. For the purposes of this rule, the following applies for submitting adverse incident reports: 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 interview and record review, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after a resident experienced a with injuries that resulted in a transfer to a hospital for	ZZ821		

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ZZ821	Continued From page 37 1 of 13 sampled residents (#7). Findings: Review of resident #7's record revealed a facility admission date of . A facility note, dated , showed the resident was found on the floor in her room. The note explained the resident complained of , in her and was taken to a hospital. On at 4:30 PM, the Administrator said the preliminary and full reports were not submitted when resident #7 and required a higher level of care because the resident did not break anything or have a serious injury. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. Unclassified	ZZ821		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department.	ZZ875		

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ZZ875	Continued From page 38 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b).	ZZ875		

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ZZ875	Continued From page 39	ZZ875		

The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a

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ZZ875	Continued From page 40 related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section	ZZ875		

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ZZ875	Continued From page 41 before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 3 of 4 sampled caregivers completed a 1-hour training program on and Related 's (ADRD) within 30 days after beginning employment (B, C, Administrator). Findings: 1. Review of the Administrator's personnel record revealed a hire date on . There was no documented evidence of a 1-hour training program on ADRD within 30 days after beginning employment from The Department of Elder Affairs. 2. Review of Caregiver B's personnel record revealed a hire date of . The record did not have documentation to show the caregiver completed a 1-hour ADRD training from The Department of Elder Affairs. On at 4:45 PM, the Business Office Manager confirmed the findings. 3. Review of Caregiver C's personnel record	ZZ875		

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WESTCHESTER OF WINTER PARK	558 N. SEMORAN BLVD. WINTER PARK, FL. 32792

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ZZ875	Continued From page 42 revealed hire date . There was no documented evidence that the 1-hour Department of Elder Affairs (DOEA) training was completed within 30 days of employment. On at 3:35 PM, an interview with the Business Office Manager confirmed the finding. On at 5:32 PM, the Administrator, Wellnes Director, and Dietary Manager confirmed the findings. Class III	ZZ875		
A 000	Initial Comments A re-licensure survey, complaint investigation # 2026005415, and generator monitoring were conducted at Westchester of Winter Park with Limited Nursing Services (LNS) on - . The facility had deficiencies at the time of the visit.	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	A 025		

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A 025	Continued From page 43 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 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	A 025		

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A 025	Continued From page 44 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure a prescribed was given without delay for 1 of 13 sampled residents (#1) and failed to follow a medication order as prescribed for 1 of 13 sampled residents (#13). Findings: On at 10:15 AM, Resident #1 said there was a delay in receiving treatment for a ( ) and as a result, she experienced , , and , , and agitation. On a health care provider ordered a for urgency and during . A lab report showed a specimen was collected on and the results were reported to the facility on . On and a health care provider ordered 100 milligram capsules, one capsule orally two times a day for five days for a . The resident's medication observation record showed the first dose of the was given on , four days after the results were reported to the facility. On at 3:15 PM, the Wellness Director explained the delay in starting the was because the pharmacy used by the facility said	A 025		

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A 025	Continued From page 45 they did not receive the order sent to them by the provider. On at 3:40 PM, advanced practice registered nurse K said that for at least the last two months, she had problems with the pharmacy saying they did not receive her orders. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. Review of Resident #13's record revealed an admission date of . His medical history included restless . 1823 indicated he needed assistance with medication self-administration. Observations made on at 10:51 AM, revealed Unlicensed Caregiver A gave Resident #13 , 0.25 milligrams (mg) 1 tablet. Review of the , Medication Observation Record (MOR) revealed , 0.25 mg with directions to give one tablet one time a day and two tablets at bedtime. Further review of the MOR indicated that , 0.25 mg, one tablet at bedtime was discontinued. Review of the , medication label only had instructions to give two tablets by at bedtime. Review of the , Medication Observation Record (MOR) revealed , 0.25 mg with directions to give one tablet one time a day and two tablets at bedtime. Further review of the more indicated that , 0.25 mg, one tablet at bedtime was discontinued. Review of the , medication label only had instructions to give two tablets by at bedtime. Additional review of the record revealed on	A 025		

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A 025	Continued From page 46 a Health Care Provider ordered , 0.25 mg, one tab by one time a day, one time only for restless , to give in addition to that night's dose and two tablets at bedtime. On , a health care provider to continue extra morning dose of , 0.2 MG for restless with the evening dose. On , a health care provider ordered , 0.25 MG, 1 tablet at bedtime for restless . The record did not have discontinuation orders for either of the , orders. During an interview on at 11:07 AM, the findings were discussed with Unlicensed caregiver A, who said she does not follow the directions on the medication label she follows the MOR. The unlicensed caregiver said the resident gets the medication in the morning and at bedtime. During an interview on at 2:45 PM, the Wellness Director (WD), said she and the nurses update the MOR when there is a new order or when there is a change with the medications. During an interview on at 9:42AM, the findings were discussed with the Wellness Director (WD), who said Resident #19 is supposed to be on , 0.25 MG, one tablet at bedtime once a day. The WD added she will need to check to verify when the , order was discontinued. The WD said the , order was the most recent order and should not have been discontinued. The WD added the other . orders should have been discontinued, and the resident is receiving too much medication. During an interview on /26 at 10:39 AM, the	A 025		

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A 025	Continued From page 47 WD said she does not have documentation for when the original order of , was discontinued. The WD added that the , order was discontinued by accident because it was viewed as a duplicate order. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. (photographic evidence obtained) Class II	A 025		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the	A 030		

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A 030	Continued From page 48 Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the	A 030		

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A 030	Continued From page 49 resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from	A 030		

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A 030	Continued From page 50 community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated	A 030		

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A 030	Continued From page 51 mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State	A 030		

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A 030	Continued From page 52 Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to take steps to prevent	A 030		

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A 030	Continued From page 53 domestic between 2 of 13 sampled residents (#7, #8). Findings: On at 3:32 PM, Caregiver B said that on at approximately 4:30 PM she heard Resident #7 screaming. The caregiver explained that when she entered the room where Residents #7 and #8, husband and wife, lived, Resident #7 was crying, motioned towards her , then said something in Spanish. The caregiver explained thar Resident #8 translated that Resident #7 said he hit her. The caregiver said Resident #8 then denied hitting Resident #7. The caregiver said she looked at Resident #7's and did not see an injury. The caregiver said she did not report the incident to the Administrator or other supervisor. The caregiver further explained that sometime in the evening on she heard Resident #7 screaming. The caregiver said that when she entered the resident's room, she saw Resident #8 hit Resident #7 on her . . . with his open . The caregiver explained that Resident #8 said Resident #7 was cheating on him and he could not do this anymore. The caregiver said she reassured Resident #8 that Resident #7 was not cheating and told Resident #8 not to hit Resident #7. The caregiver said Resident #7 was crying when Resident #8 hugged and apologized to her. The caregiver said she did not see a visible injury on Resident #7's . The caregiver explained that police were called and when they arrived both residents were asleep. The caregiver said that following the incident she kept their door open. The caregiver said she did not notify their family of the incident. On at 4:30 PM, both the Administrator and the Wellness Director said they were not told	A 030		

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A 030	Continued From page 54 about the incident that occurred on . On at 4 PM, Caregiver A said that sometime after dinner on she responded to the resident's room where she saw Resident #7 crying. The caregiver said that Resident #8 was rambling, said Resident #7 cheated on him, said they needed to see a priest, and said he needed to make more money to support them. The caregiver said she phoned the Wellness Director, who instructed her to call police and to offer to move one of the residents. The caregiver said she called police and did not offer to move one of the residents because she did not think it was necessary. The caregiver said she did not notify their family of the incident. The caregiver said she instructed the next shift to check on the residents every thirty minutes. On at 9:40 AM, Residents #7 and #8 were seen together in their room. Resident #8 said that on the night of resident #7 tried to get out of bed. Resident #8 explained there was no physical contact between them and the two of them cooled off. Resident #8 declined to explain the reason for the disagreement stating it was personal. Resident #7 said the previous night's incident occurred when resident #8 could not form a sentence and did not make sense. Resident #7 said she asked resident #8 what happened. Resident #7 explained that when she stood up and touched resident #8, he told her not to touch him. Resident #7 said she started to cry and left the room to find someone to help. Resident #7 said resident #8 asked who she was going to talk to. Resident #7 said it never became physical and that resident #8 never put his on her. Both residents said no staff offered to move one of them.	A 030		

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A 030	Continued From page 55 On at 3:02 PM, Resident #7's and #8's family said no one from the facility informed him of the incident. The family member said the residents argued in the past but were never physical with each other. On at 4:52 PM, advanced practice registered nurse (APRN) K said she was not informed of either incident. The APRN said that during a prior visit Resident #7 denied that Resident #8 was agitated towards her. The APRN said Resident #8 was oriented only to people and that his was not sudden or acute. The APRN said Resident #7 was oriented to person and place. On at 4:25 PM, Resident #7 was seen alone in a different room. The resident said Resident #8 did not hit her. When asked about staff observing Resident #8 hit her, Resident #7 remained quiet. The facility's policy, dated , defined as hitting, slapping, pinching, pulling, and kicking. The policy read that any employee of the facility having either direct or indirect knowledge of must report it promptly. The steps to report were required immediately and included reporting the allegation to the Administrator, to the Director of Clinical Services, to the supervisor of the reporter's choice, and to the Department of Children and Family Services. The policy documented that any individual found to be in danger of injury will be removed from the source of the suspected behavior. On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings.	A 030		

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	AL11942716	A. BUILDING: _____ B. WING _____	04/30/2026

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A 030	Continued From page 56 Class II	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being	A 032		

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A 032	Continued From page 57 assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to have documentation that 3 of 4 sampled staff participated in a minimum of two resident elopement drills each year (A, C, Administrator). Findings: 1. Review of the Administrator's personnel record revealed a hire date on . There was no documented evidence that a minimum of 2 drills	A 032		

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A 032	Continued From page 58 were conducted. On at approximately 4:15 PM, the Administrator stated no one has elopement drills. Adding, since he started in , last year no drills were done. 2. Review of Caregiver A's personnel record revealed a hire date of . During an interview on at 4:24 PM, with the Business Office Manager (BOM), the elopement drills were requested. During an interview on at 4:43 PM, with the Administrator, the elopement drills were requested from the Administrator. On at 5 PM, no additional documentation was provided. 3. Review of Caregiver C's personnel record revealed hire date . There was no documented evidence she participated in two (2) elopement drills for 2025 as required. On at 4 PM, an interview with the Business Office Manager confirmed the finding. On at 5:32 PM, the Administrator and Wellness Director confirmed the findings. Class III	A 032		
A 040 SS=D	429.55(2) F.S. Resident Education- (V (2) VTE CONSUMER INFORMATION.-	A 040		

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A 040	Continued From page 59 (a) The Legislature finds that many , (PEs) are preventable and that information about the prevalence of the could save lives. (b) The term ", " means a condition in which part of the clot breaks off and travels to the , possibly causing . (c) The term " " means , , which is a clot located in a deep , usually in the or arm. The term can be used to refer to , , , or both. (d) Assisted living facilities must provide a consumer information pamphlet to residents upon admission. The pamphlet must contain information about , including risk factors and how residents can recognize the signs and symptoms of . This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide a consumer information pamphlet about , including risk factors and how residents can recognize the signs and symptoms of to 4 of 4 sampled residents upon admission (#1, #7, #8, #9). Findings: Review of Resident #1's record revealed a facility admission date of . Review of Resident #7's record revealed a facility admission date of . Review of Resident #8's record revealed a facility admission date of .	A 040		

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A 040	Continued From page 60 Review of Resident #9's record revealed a facility admission date of . None of the records had documentation to indicate they were provided with a consumer information pamphlet about , including risk factors and how residents can recognize the signs and symptoms of . On at 2:05 PM, the Administrator said the information was not provided because he was unaware of the requirement. Class III	A 040		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone	A 054		

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A 054	Continued From page 61 number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain complete medication observation records (MORs) for 3 of 13 sampled residents (#1, #17, #18) and failed to maintain the correct medication directions on the MOR for 1 of 5 sampled residents (#19) who require assistance with self-administration of medication. Findings: 1. Review of Resident #19's record revealed an health assessment (1823). The resident has a diagnosis of and requires assistance with self-administration of medication. Review of the MOR revealed , 50 milligrams (mg) tablet, 1.5 tab (75 mg) orally one time a day. The record revealed on a Health Care Provider ordered , 50 mg, 1.5 (75 mg) tablets orally three times a day. During an interview on at 1:43 PM, Unlicensed Caregiver A said the resident gets the medication three times a day and she did not realize the directions only said one time a day on	A 054		

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A 054	Continued From page 62 the MOR. During an interview on at 1:50 PM, Resident #19 said he gets the correct dosage of and gets the medication three times a day. During an interview on at 9:36 AM, the findings were discussed with the Wellness Director (WD), who confirmed the findings of the MOR not being updated to reflect the correct directions for . 2. Resident #1's , and MORs showed omissions where medications were not signed as given. Neither the MORs nor the resident's record had documentation explaining the reason. On at 12:50 PM, the findings were discussed with the Wellness Director. On at 3:15 PM, the Wellness Director said there was no additional documentation to explain the omissions. 3. A review for Resident #17 record revealed date of admission . The last 1823 health assessment dated listed medical history of type 2, following , and major . He needs assistance with self-administration of medications. In further review of the last three months of Medication Observation Record (MORs) had holes indicating the medications was not given for the following days below:	A 054		

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A 054	Continued From page 63 5mg-holes 81mg-holes D3 125mg-holes 400mg-holes 500mg-holes 1000mg-holes 5mg-holes 81mg-holes D3 125mcg-holes 400mg-holes 1000mg-holes 5mg-holes 81mg-holes D3 125mcg-holes 400mg-holes 500mg-holes 1000mg-holes 4. Review of Resident #18's record revealed date of admission . The 1823 health assessment dated listed medical history of acute and failure with ; obese due to excess calories; essential ; type 2 with , dry , sleep , ( ) with acute exacerbation, and dependency. Furthermore,	A 054		

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A 054	Continued From page 64 the 1823 health assessment documented that he could administer his own medications. On at 9:32 AM, an interview with the Wellness Director said that Resident #18 asked the facility to assist with self-administration of medications and confirmed that she did not get a new order for direction for medication assistance. A review of the , MORs listed the holes for medications below: , , 2mg-holes 6.25mg-holes 30mg-holes , 300mg-holes One Day / -holes - , 40mg-holes Polyvinyl , solution 1.4%-holes , , 25mg-holes 8.6mg-holes , , , 25mg-holes 50mg-holes B1 100mg-holes - 500mg-holes On at 10:39 AM, an interview with the Wellness Director confirmed the findings and further said that she had reprimanded in writing (disciplinary action) for Unlicensed Caregiver C on and ; and for Unlicensed Caregiver G on after an audit was completed for residents that both of them assisted medications and not signing off on the MORs while they worked 3rd shift as required. In addition, the Wellness Director stated that she conducted training on all unlicensed caregivers and nurses on , and .	A 054		

Agency for Health Care Administration

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A 054	Continued From page 65 On at 5:32 PM, the Administrator, Wellness Director, and Dietary Manager confirmed the findings. (Photographic Evidence Obtained) Class III	A 054		